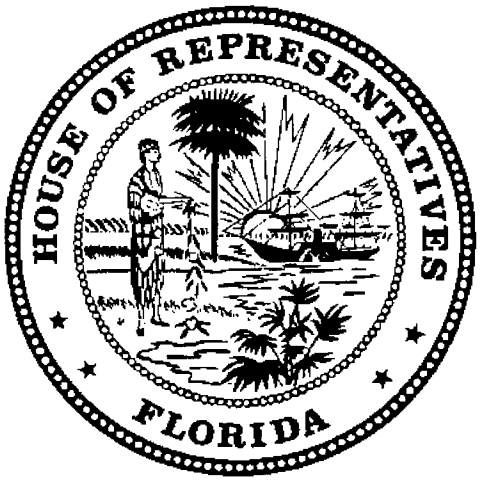

Fiscal Council

Joe Negron, Chair
Fred Brummer, Vice Chair

December 06, 2005
9:30 a.m. – 12:00 p.m.
Morris Hall

Allan G. Bense
Speaker

Joe Negron
Chair

Council Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Allan G. Bense

Fiscal Council

Start Date and Time:	Tuesday, December 06, 2005 09:30 am
End Date and Time:	Tuesday, December 06, 2005 12:00 pm
Location:	Morris Hall (17 HOB)
Duration:	2.50 hrs

Consideration of the following bill(s):

HB 3B CS (IF RECEIVED) -- Medicaid by Benson
HB 47B Appropriation to Compensate Wilton Dedge by Goodlette, Quinones
HB 41B Judges by Goodlette
HB 31B (IF RECEIVED) -- Specialty License Plates by Patterson
HB 15B (IF RECEIVED) -- Ad Valorem Property Tax Payment Discounts by Hasner
HB 1B (IF RECEIVED) -- Slot Machine Gaming by Business Regulation Committee

NOTICE FINALIZED on 12/05/2005 19:20 by SLB

Florida House of Representatives

Fiscal Council

Allan Bense
Speaker

Joe Negron
Chair

AGENDA
December 6, 2005
9:30 a.m. – 12:00 p.m.
Morris Hall

I. **Meeting Call to Order**

II. **Opening Remarks by Chair**

III. **Consideration of the following bill(s):**

HB 3B CS (IF RECEIVED) -- Medicaid by Benson

HB 47B Appropriation to Compensate Wilton Dedge by Goodlette, Quinones

HB 41B Judges by Goodlette

HB 31B (IF RECEIVED) -- Specialty License Plates by Patterson

HB 15B (IF RECEIVED) -- Ad Valorem Property Tax Payment Discounts by Hasner

HB 1B (IF RECEIVED) -- Slot Machine Gaming by Business Regulation Committee

IV. **Closing Remarks and Adjournment**

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 3B CS Medicaid
SPONSOR(S): Benson
TIED BILLS: **IDEN./SIM. BILLS:** SB 2B

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	6 Y, 4 N, w/CS	Mitchell	Mitchell
2) Fiscal Council		Speir	Kelly
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

In the 2005 Regular Session the Legislature passed CS/CS/SB 838 (Ch. 2005-133, L.O.F.), which establishes s. 409.91211, F.S., to give the Agency for Health Care Administration (AHCA) guidance and authority to seek a federal waiver to reform Medicaid, and specified the agency could not implement the waiver until it received authority from the Legislature. On October 3, 2005, AHCA submitted the waiver to the federal Centers for Medicare and Medicaid Services (CMS) for approval, following a year of negotiation with CMS. On October 19, 2005, the federal Centers for Medicare and Medicaid Services (CMS) approved Florida's Medicaid Reform waiver application with special terms and conditions.

HB 3B with CS amends s. 409.91211, F.S., to give AHCA authority to implement Medicaid reform as required by CS/CS/SB 838, and in accordance with CMS special terms and conditions. It also amends ss. 216.346, 409.911, 409.912, 409.9122, and 641.2261, Florida Statutes and creates ss. 11.72 and 409.91212, Florida Statutes.

The bill provides an appropriation of $250,000, and an FTE to the Office of Insurance Regulation to carry out an annual review of the risk-adjusted rate methodology.

The effective date of the bill is upon becoming law.

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government. The bill requires outsourcing of the administration of health care service delivery to managed care plans approved by the Agency for Health Care Administration.

B. EFFECT OF PROPOSED CHANGES:

HB 3B with CS amends s. 409.91211, F.S., to give AHCA authority to implement the reform plan as established in the waiver application and federal terms and conditions for the waiver.

The bill:

- Requires Medicaid provider service networks to comply with certain federal solvency requirements, rather than state solvency requirements for HMOs.
- Modifies the name, composition, and mission of the existing Medicaid Disproportionate Share Council.
- Establishes Low Income Pool Council objectives for the distribution of LIP funds. The revised Council will make recommendations to the Legislature regarding the Low Income Pool, which replaces the UPL funding program for safety-net hospitals.
- Allows current capitated, behavior health programs to continue in non-reform counties.
- Facilitates the establishment of PSNs by, removing the requirement that contracts for Provider Service Networks (PSNs) be competitively bid, so hospitals and other provider networks can be established to participate in Medicaid reform.
- Authorizes AHCA to begin implementing the Medicaid managed care pilot program in two sites, Broward and Duval Counties.
- Authorizes AHCA to seek options to make direct payments to state medical school hospitals and physicians.
- Requires PSNs to continue sharing savings with the state as PSNs transition to managed care reform plans.
- Allows the Department of Health's, Children's Medical Services Network, to become a reform plan.
- Establishes detailed measures that require quality assurance, patient satisfaction, and performance standard reporting by managed care reform plans.
- Establishes detailed standards for managed care plan compliance, including patient encounter reporting requirements.
- Establishes detailed requirements to minimize the risk of Medicaid fraud and abuse in all plans operating in the Medicaid managed care pilot program.
- Requires AHCA to assign Medicaid recipients who are currently in a Medicaid managed care plan and who do not make a choice of a plan at the point of eligibility redetermination into the most appropriate reform plan operated by the recipient's current managed care organization.
- Requires AHCA to notify the Legislature before proposing any changes to the terms and conditions of the waiver.
- Requires the Office of Insurance Regulation to advise AHCA and report to the Legislature on the proposed risk-adjusted rate methodology developed for Medicaid reform plans; a four year phase in of the risk-adjusted rates; limits on variation in rates based on risk, with hold harmless on plan payments; and federal approval of risk adjusted rates.

- Requires rule making for risk-adjusted rate-setting and for choice counseling of beneficiaries.
- Establishes a Joint Legislative Committee on Medicaid Reform Implementation for reviewing policy issues related to expansion.
- Establishes detailed requirements for readiness that must be met before expansion into other counties can be considered beginning in year two. At least two plans in the expansion area must meet readiness criteria.
- Mandates the assignment of Medicaid recipients in non-reform counties to a managed care plan when they fail to select a service delivery system.
- Requires AHCA to report to the Legislature by April 1, 2006, on Low Income Pool methodology and other issues related to the special terms and conditions.
- Requires AHCA to submit all CMS required quarterly and annual progress reports to the Legislature.
- Specifies legislative intent that, if any conflict exists between the statutory provisions relating to reform and other Medicaid statutes, the requirements of reform prevail. AHCA must report to the Legislature any conflicts it identifies.
- Provides an appropriation of $250,000 for the Office of Insurance Regulation to carry out the annual review of the risk-adjusted rate methodology.
- Provides an effective date of upon becoming law, so that AHCA can implement Medicaid Reform.

THE CURRENT SITUATION

Medicaid is the $15 billion state and federal program that provides health care to more than 2.1 million vulnerable, disabled, and elderly Floridians. According to AHCA, if Florida's Medicaid program continues to grow at its present rate, it would consume more than half of the state's budget by 2015.

Governor Bush's Proposal for Medicaid Reform

In 2004, Governor Bush proposed a major reform of Florida's Medicaid system, and the Agency for Health Care Administration (AHCA) began meeting with the federal Centers for Medicare and Medicaid Services (CMS) to develop concepts for the reform. The reform is referred to as a "waiver" because it seeks federal permission to waive certain federal requirements that govern the regular Medicaid program. The goals of the reform are to establish a new Medicaid system that achieves:

Patient Choice: Participants in reformed Medicaid plans will be able to choose among a variety of benefit packages. With the help of independent choice counselors they will choose the plan that best meets their needs. They will be able to earn credits for approved health-related expenses such as co-pays, over-the-counter medications, or eyeglasses, by meeting approved healthy lifestyle changes such as meeting all well baby checkups, losing weight, and smoking cessation.

Medicaid Marketplace Innovation: Provider groups will be able to design benefit plans that attract participants because of their benefit package, innovative care, convenient networks, and optional services. Competition among managed care plans will reduce fraud in Medicaid. Currently, Medicaid pays claims first and identifies fraud later. Under proposed reforms, capitated health plans have a financial incentive to aggressively guard against fraud.

Better Care: Health plans can customize their benefit design to meet the needs of the target populations in the geographic areas they serve. The state will evaluate the benefits to ensure they are actuarially equivalent to historical fee-for-service benefits and are sufficient to meet the needs of the targeted populations. Rates will be risk adjusted to create incentives for more prevention and identification of chronic illnesses.

Budget Predictability: According to the Agency for Health Care Administration, by moving to a managed and capitated system, the state expects to minimize budget fluctuations driven primarily by the current fee-for-service system and improve predictions of budget growth.

2004-2005 Legislative Action on Medicaid Reform

In the Fall of 2004, both the House and Senate established Select Committees on Medicaid Reform. The Select Committees conducted five public hearings in cities around the state, including Tampa, Ft. Lauderdale, Orlando, Panama City, and Jacksonville. During the public hearings, the Select Committees heard testimony from hundreds of individuals including Medicaid recipients, providers, health maintenance organization (HMO) representatives, advocacy groups, and other interested parties on ways to improve the Medicaid program.

CS/CS/SB 838 Authorization and Requirements to Pursue a Federal Waiver

In 2005, the Legislature passed CS/CS/SB 838, which creates s. 409.91211, F.S., to authorize AHCA to continue developing a plan to pilot the Governor's proposal for a capitated managed care system to replace the current fee-for-service Medicaid system. Requirements of SB 838 include:

Continued federal funding of supplemental payment mechanisms. The law specifies that the authorization was contingent on the attainment of:

- Federal approval to preserve the Upper Payment Limit (UPL) funding for hospitals, including a guarantee of a reasonable growth factor.
- A methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites.
- Provisions to preserve the state's ability to use Intergovernmental Transfers (IGT) as state match for federal funds.
- Provisions to protect the Disproportionate Share Hospital (DSH) program.

Components for the reform plan. The law requires AHCA to develop and recommend provisions for implementation of Medicaid reform pilot areas that include:

- Eligibility groups and two geographic areas for the pilot projects. The bill designates one pilot program in Broward County and one pilot program in Duval and surrounding Baker, Clay, and Nassau Counties. It allows the pilot in the Duval County area to be phased in over a 2-year period.
- Requirements that health care plans in Medicaid reform pilot areas include mandatory and optional Medicaid services listed in ss. 409.905 and 409.906, F.S.
- Standards and credentialing requirements for plans, including those related to fiscal solvency, quality of care, and adequacy of access to health care providers.
- Actuarially sound, risk adjusted capitation rates for coverage of Medicaid recipients separated into comprehensive and catastrophic care premium components, and a method to phase in financial risk for approved provider service networks over a 3-year period, with stop-loss requirements.
- A system to help Medicaid recipients select a managed care plan that meets their needs. Requirements for mandatory enrollment in a capitated managed care network and locking a recipient into a health plan for 12 months, unless the recipient can demonstrate cause to justify a disenrollment, and provisions for disenrollment and selection of another plan within a certain timeframe.
- A system to monitor plan performance and the provision of services, and to detect and deter fraud and abuse by health plans, providers, and recipients, including underutilization and inappropriate denial of care.

Approval of an implementation plan. Section 409.91211, F.S, requires AHCA to develop an implementation plan to be submitted to the Legislature for approval before implementation of the reform, or if the Legislature is not in session, for approval by the Legislative Budget Commission.

Evaluation of the pilots. The Legislature also requires an independent evaluation of Medicaid reform for consideration of expansion beyond the pilot areas. The Office of Program Policy Analysis and Government Accountability (OPPAGA), in consultation with the Auditor General, will evaluate the two managed care pilot projects during the first 24 months of operation. The evaluation must contain cost savings estimates and quality measures, as well as explanations of any legal or administrative barriers to implementing the pilot projects. The evaluation must be included in a report to the Governor and the Legislature no later than June 30, 2008, for consideration of statewide expansion.

Legislature approval of expansion. No additional counties beyond those specified in s. 409.91211, F.S., may be included in the managed care pilot program without legislative authority.

Federal Approval of the Waiver

The Agency for Health Care Administration (AHCA) published the waiver application for public review on August 31, 2005, and formally submitted the waiver application to the federal government for approval on October 3, 2005.

The federal Centers for Medicaid and Medicare Services (CMS) approved the waiver for reform of Florida Medicaid on October 19, 2005. The waiver covers a 5-year period, from July 1, 2006, through June 30, 2011. Fundamental elements of the reform plan include:

Beneficiary Choice from among benefit packages. With the support of choice counselors, individuals will have the flexibility to choose from a variety of benefit packages and pick the plan that best meets their needs.

Plan Variety. In addition to traditional managed care organizations, new plans will be created from existing provider networks and organizations that wish to participate. Such entities include provider service networks, federally qualified health centers, federally qualified rural health clinics, county health departments, the Division of Children's Medical Services Network within the Department of Health; and other federally, state, or locally funded entities that serve the geographic areas within the pilot program.

Risk-Adjusted Premiums for Medicaid enrollees in managed care plans. The premium will have two components, comprehensive care and catastrophic care, and will be actuarially comparable to all services covered under the current Florida Medicaid program.

A Low-Income Pool (LIP) to be established and maintained by the state to provide direct payment and distributions to safety-net providers in the state for the purpose of providing coverage to the uninsured through provider access systems.

An Employer-Sponsored Insurance (ESI) option to allow individuals to use their premiums to "opt out" of Medicaid and purchase insurance through their workplace.

Enhanced Benefits Accounts to provide incentives to Medicaid Reform enrollees for healthy behaviors that they can use to offset health-care-related costs, such as over-the-counter pharmaceuticals, vitamins, etc.

Federal Terms and Conditions
In approving the waiver, CMS attached special terms and conditions (11-W-00206/4) that set forth in detail the nature, character, and extent of federal involvement in the reform, and Florida's obligations to CMS during the life of the waiver. The terms and conditions address 120 issues in 16 areas of the reform. They require detailed accountability. The terms and conditions require compliance with current Medicaid law, regulation, and policy. They spell out limits on the scope of change in some areas, and provide for broad flexibility in others. The areas addressed by the terms and conditions include:

- General Program and Reporting Requirements.
- Implementation of Florida Medicaid Reform.
- Eligibility, Enrollment, and Choice Counseling.
- Benefit Packages and Medicaid Reform Plans.
- Employer-Sponsored Insurance.
- The Enhanced Benefits Accounts Program.
- The Low Income Pool.
- Evaluation and Monitoring of Budget Neutrality.

The primary condition of the Medicaid waiver is "budget neutrality." A federal rule requires that the costs of Medicaid services provided to recipients under the waiver must not exceed the projected costs for Medicaid services without the waiver. If expenditures exceed the budget neutrality projections, then the state will have to fund these expenditures without federal matching funds.

The terms and conditions require federal approval of amendments to the waiver before Florida can add dual eligible, hospice, and medically needy groups to the reform; and before any program or budget changes can be made to: eligibility, enrollment, benefits, employer-sponsored insurance, implementation, the Low Income Pool, Federal Financial Participation (FFP), sources of the non-Federal share, and budget neutrality.

C. SECTION DIRECTORY:

Section 1. Amends s. 641.2261(2), F.S., to require Medicaid provider service networks to comply with certain federal solvency requirements, rather than state solvency requirements for HMOs.

Section 2. Amends s. 409.911(9), F.S., to modify the name, composition, and mission of the existing Medicaid Disproportionate Share Council. The revised Council will make recommendations to the Legislature regarding the Low Income Pool, which replaces the UPL funding program for safety-net hospitals under the terms and conditions of the federal waiver.

Section 3. Amends s. 409.912, F.S., to allow current capitated, behavior health programs to continue in non-reform counties, and remove the requirement that contracts for Provider Service Networks (PSNs) be competitively bid.

Section 4. Amends s. 409.91211, F.S., to authorize AHCA to begin implementing the Medicaid managed care pilot program in two pilot sites (Broward and Duval Counties per CS/CS/SB 838, 2005). The bill specifies additional requirements related to PSN cost sharing, quality assurance, encounter data, fraud and abuse, and continuity of care; it limits implementation of risk-adjusted rate setting; and it makes technical changes to conform to requirements of the federal waiver.

Section 5. Creates s. 409.91212, F.S., to allow Medicaid reform to expand to other counties after the beginning of year two, if detailed criteria for readiness are met.

Section 6. Amends s. 409.9122, F.S., to remove the requirement of automatic assignment into Medipass of Medicaid recipients in non-reform counties who do not make a choice of plans.

Section 7. Requires AHCA to report to the Legislature by April 1, 2006, on the Low Income Pool methodology and other issues related to the federal terms and conditions requirements of the waiver.

Section 8. Requires AHCA to submit all CMS required quarterly and annual reports to the Legislature.

Section 9. Creates s. 11.72, F.S., to establish a Joint Legislative Committee on Medicaid Reform Implementation to review policy issues related to expansion of the Medicaid managed pilot program and make recommendations regarding the extent readiness criteria are met.

Section 10. Specifies legislative intent that, if any conflict exists between the statutory provisions relating to reform and other Medicaid statutes, the requirements of reform prevail. AHCA must report to the Legislature any conflicts it identifies.

Section 11. Amends s. 216.346, F.S., to allow contracts between state agencies and state colleges and universities to charge a reasonable overhead.

Section 12. Provides an appropriation of $250,000, for the Office of Insurance Regulation to carry out the annual review of the risk-adjusted rate methodology.

Section 13. Provides an effective date of upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Comments below.

2. Expenditures:

   See Comments below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Medicaid reform will change the way Medicaid services are provided to Medicaid recipients. This may have a direct impact on the fees service providers receive.

D. FISCAL COMMENTS:

Administration Costs

The Agency for Health Care Administration has requested $15 million ($7.5 million General Revenue) of nonrecurring funds for the administration of Medicaid reform in its Fiscal Year 2006-2007 Legislative Budget Request. The request is for the following funds.

Choice Counseling

General Revenue Fund	$3,250,000
Administrative Trust Fund	$3,250,000
Plan Evaluation/Satisfaction Survey	
General Revenue Fund	$250,000
Administrative Trust Fund	$250,000
Premium Development	
General Revenue Fund	$1,000,000
Administrative Trust Fund	$1,000,000
Enhanced Benefit Accounts	
General Revenue Fund	$1,500,000
Administrative Trust Fund	$1,500,000
Management of Employer Sponsored Insurance	
General Revenue Fund	$1,000,000
Administrative Trust Fund	$1,000,000
Infrastructure & System Modification	
General Revenue Fund	$500,000
Administrative Trust Fund	$500,000

For subsequent years, the agency states that the projects will increase in cost as the capitated managed care pilot program expands into Baker, Clay, and Nassau counties.

Medicaid Reform Benefit Costs

The agency's Florida Medicaid Reform Implementation Plan dated November 28, 2005, compares the costs of Medicaid benefits without Medicaid reform to the costs of Medicaid benefits with Medicaid reform. The comparison is below.

Benefit Costs	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
Without reform	$8,005,381,618	$9,074,633,163	$10,317,423,381	$11,763,265,977	$13,446,859,984
With reform	$7,814,617,174	$8,747,049,308	$9,823,408,828	$11,067,673,309	$12,507,991,943
Difference	$190,764,444	$327,583,855	$494,014,553	$695,592,668	$938,868,041

The $190.7 million in savings shown above for Fiscal Year 2006-2007 is for statewide expenditures. According to the agency, the fiscal impact of moving recipients into Medicaid reform plans in only Duval and Broward counties is indeterminate at this time.

The agency estimates that the phasing in risk-adjusted rates will reduce the amount of the agency's projected cost savings.

Rate Review

This bill authorizes one full-time equivalent position and appropriates $250,000 from the General Revenue Fund for Fiscal Year 2006-2007 for the annual review of the Medicaid managed care pilot program's risk-adjusted rate setting methodology.

Assignment of Recipients to Managed Care

The bill changes the assignment of undecided enrollees. The agency estimates that this policy change would result in savings of more than $12.2 million ($4.2 million General Revenue).

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Paragraph (c) on page 40 places a duty on the agency in a subsection that grants powers to the Office of Insurance Regulation.

Subsection (8) on page 40 requires the agency to set rates based upon the "recommendation of the committee" without knowing what committee is being referenced. The language also appears to make the agency's rate setting authority subject to another entity. This may violate the single state agency requirements in federal law (See 42 CFR 431.10).

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On December 5, 2005, the Health Care Regulation Committee adopted two amendments sponsored by Representative Garcia. The Committee Substitute differs from the original bill as filed. The Committee Substitute adds language to require: the Office of Insurance Regulation to advise AHCA, not oversee, the proposed risk-adjusted rate system; a four year phase in of the risk-adjusted rates; limits on variation in rates based on risk, with hold harmless on plan payments; federal approval of risk adjusted rates; and rule making for risk-adjusted rate-setting and for choice counseling of beneficiaries.

The bill, as amended, was reported favorably as a committee substitute.

This analysis is drafted to the committee substitute.

CHAMBER ACTION

The Health Care Regulation Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to Medicaid; amending s. 641.2261, F.S.; revising the applicability of solvency requirements to include Medicaid provider service networks and updating a reference; amending s. 409.911, F.S.; renaming the Medicaid Disproportionate Share Council; providing for appointment of council members; providing responsibilities of the council; amending s. 409.912, F.S.; providing an exception from certain contract procurement requirements for specified Medicaid managed care pilot programs and Medicaid health maintenance organizations; deleting the competitive procurement requirement for provider service networks; requiring provider service networks to comply with the solvency requirements in s. 641.2261, F.S.; updating a reference; amending s. 409.91211, F.S.; providing for distribution of upper payment limit, hospital disproportionate share program, and low income pool funds; providing legislative intent with respect to distribution of said funds; providing for implementation

of the powers, duties, and responsibilities of the Agency for Health Care Administration with respect to the pilot program; including the Division of Children's Medical Services Network within the Department of Health in a list of state-authorized pilot programs; requiring the agency to develop a data reporting system; requiring the agency to implement procedures to minimize fraud and abuse; providing that certain Medicaid and Supplemental Security Income recipients are exempt from s. 409.9122, F.S.; authorizing the agency to assign certain Medicaid recipients to reform plans; authorizing the agency to implement the provisions of the waiver approved by Centers for Medicare and Medicaid Services and requiring the agency to notify the Legislature prior to seeking federal approval of modifications to said terms and conditions; requiring the agency to adopt certain rules for the managed care pilot program; requiring the Office of Insurance Regulation to provide advisory recommendations regarding the agency's rate setting methodology; authorizing the office to enter into certain contracts; requiring the agency to solicit input from certain stakeholders regarding the agency's rate setting methodology; requiring a report to the Governor and Legislature; providing for implementation of adjustments to risk-adjusted capitation rates by agency rule; providing a schedule for the phasing in of capitation rates; providing requirements for adjustments to capitation rates; requiring certification of capitation

rates; defining the term "capitated managed care plan"; creating s. 409.91212, F.S.; authorizing the agency to expand the Medicaid reform demonstration program; providing readiness criteria; providing for public meetings; requiring notice of intent to expand the demonstration program; requiring the agency to request a hearing by the Joint Legislative Committee on Medicaid Reform Implementation; authorizing the agency to request certain budget transfers; amending s. 409.9122, F.S.; revising provisions relating to assignment of certain Medicaid recipients to managed care plans; requiring the agency to submit reports to the Legislature; specifying content of reports; creating s. 11.72, F.S.; creating the Joint Legislative Committee on Medicaid Reform Implementation; providing for membership, powers, and duties; providing for conflict between specified provisions of ch. 409, F.S., and requiring a report by the agency pertaining thereto; amending s. 216.346, F.S.; revising provisions relating to contracts between state agencies; providing an appropriation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 641.2261, Florida Statutes, is amended to read:

641.2261 Application of federal solvency requirements to provider-sponsored organizations and Medicaid provider service networks.--

(1) The solvency requirements of ss. 1855 and 1856 of the Balanced Budget Act of 1997 and 42 C.F.R. s. 422.350, subpart H, ~~rules adopted by the Secretary of the United States Department of Health and Human Services~~ apply to a health maintenance organization that is a provider-sponsored organization rather than the solvency requirements of this part. However, if the provider-sponsored organization does not meet the solvency requirements of this part, the organization is limited to the issuance of Medicare+Choice plans to eligible individuals. For the purposes of this section, the terms "Medicare+Choice plans," "provider-sponsored organizations," and "solvency requirements" have the same meaning as defined in the federal act and federal rules and regulations.

(2) The solvency requirements of 42 C.F.R. s. 422.350, subpart H, and the solvency requirements established in the approved federal waiver pursuant to chapter 409 apply to a Medicaid provider service network rather than the solvency requirements of this part.

Section 2. Subsection (9) of section 409.911, Florida Statutes, is amended to read:

409.911 Disproportionate share program.--Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share

of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(9) The Agency for Health Care Administration shall create a Medicaid Low Income Pool ~~Disproportionate Share~~ Council. The Low Income Pool Council shall consist of 17 members, including three representatives of statutory teaching hospitals, three representatives of public hospitals, three representatives of nonprofit hospitals, three representatives of for-profit hospitals, two representatives of rural hospitals, two representatives of units of local government which contribute funding, and one representative from the Department of Health. The council shall have the following responsibilities:

(a) Make recommendations on the financing of the upper payment limit program, the hospital disproportionate share program, or the low income pool as implemented by the agency pursuant to federal waiver and on the distribution of funds.

(b) Advise the agency on the development of the low income pool plan required by the Centers for Medicare and Medicaid Services pursuant to the Medicaid reform waiver.

(c) Advise the agency on the distribution of hospital funds used to adjust inpatient hospital rates and rebase rates or otherwise exempt hospitals from reimbursement limits as financed by intergovernmental transfers.

~~(a) The purpose of the council is to study and make recommendations regarding:~~

~~1. The formula for the regular disproportionate share program and alternative financing options.~~

~~2. Enhanced Medicaid funding through the Special Medicaid Payment program.~~

~~3. The federal status of the upper-payment-limit funding option and how this option may be used to promote health care initiatives determined by the council to be state health care priorities.~~

~~(b) The council shall include representatives of the Executive Office of the Governor and of the agency; representatives from teaching, public, private nonprofit, private for-profit, and family practice teaching hospitals; and representatives from other groups as needed.~~

(d) ~~(c) The council shall~~ submit its findings and recommendations to the Governor and the Legislature no later than February 1 of each year.

Section 3. Paragraphs (b) and (d) of subsection (4) of section 409.912, Florida Statutes, are amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion

shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as

Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(4) The agency may contract with:

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver

provided for by s. 409.905(5). Such an entity must be licensed under chapter 624, chapter 636, or chapter 641 and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 8. and except in counties where the Medicaid managed care pilot program is authorized under s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a Medicaid capitated managed care plan authorized under s. 409.91211 or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized under s. 409.91211 in one or more counties, the agency may procure a

contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Each entity must offer sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the managed care plan with a certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

1. By January 1, 2001, the agency shall modify the contracts with the entities providing comprehensive inpatient and outpatient mental health care services to Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance abuse treatment services.

2. By July 1, 2003, the agency and the Department of Children and Family Services shall execute a written agreement that requires collaboration and joint development of all policy, budgets, procurement documents, contracts, and monitoring plans that have an impact on the state and Medicaid community mental health and targeted case management programs.

3. Except as provided in subparagraph 8., by July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance organization or a Medicaid capitated managed care plan authorized under s. 409.91211. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid health maintenance organization or a Medicaid capitated managed care plan authorized under s. 409.91211 in AHCA areas where the eligible population exceeds 150,000. In an AHCA area where the Medicaid managed care pilot program is authorized under s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an

adjacent AHCA area and shall be subject to this paragraph. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations shall be eligible to compete. Managed care plans contracting with the agency under subsection (3) shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference. In AHCA area 11, the agency shall contract with at least two comprehensive behavioral health care providers to provide behavioral health care to recipients in that area who are enrolled in, or assigned to, the MediPass program. One of the behavioral health care contracts shall be with the existing provider service network pilot project, as described in paragraph (d), for the purpose of demonstrating the cost-effectiveness of the provision of quality mental health services through a public hospital-operated managed care model. Payment shall be at an agreed-upon capitated rate to ensure cost savings. ~~Of the recipients in area 11 who are assigned to MediPass under the provisions of s. 409.9122(2)(k),~~ A minimum of 50,000 ~~of those~~ MediPass-enrolled recipients shall be assigned to the existing provider service network in area 11 for their behavioral care.

4. By October 1, 2003, the agency and the department shall submit a plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides for the full implementation of capitated prepaid behavioral health care in all areas of the state.

a. Implementation shall begin in 2003 in those AHCA areas of the state where the agency is able to establish sufficient capitation rates.

b. If the agency determines that the proposed capitation rate in any area is insufficient to provide appropriate services, the agency may adjust the capitation rate to ensure that care will be available. The agency and the department may use existing general revenue to address any additional required match but may not over-obligate existing funds on an annualized basis.

c. Subject to any limitations provided for in the General Appropriations Act, the agency, in compliance with appropriate federal authorization, shall develop policies and procedures that allow for certification of local and state funds.

5. Children residing in a statewide inpatient psychiatric program, or in a Department of Juvenile Justice or a Department of Children and Family Services residential program approved as a Medicaid behavioral health overlay services provider shall not be included in a behavioral health care prepaid health plan or any other Medicaid managed care plan pursuant to this paragraph.

6. In converting to a prepaid system of delivery, the agency shall in its procurement document require an entity providing only comprehensive behavioral health care services to prevent the displacement of indigent care patients by enrollees in the Medicaid prepaid health plan providing behavioral health care services from facilities receiving state funding to provide indigent behavioral health care, to facilities licensed under chapter 395 which do not receive state funding for indigent

behavioral health care, or reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent care patient.

7. Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394, child welfare providers under contract with the Department of Children and Family Services in areas 1 and 6, and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

8. For fiscal year 2004-2005, all Medicaid eligible children, except children in areas 1 and 6, whose cases are open for child welfare services in the HomeSafeNet system, shall be enrolled in MediPass or in Medicaid fee-for-service and all their behavioral health care services including inpatient, outpatient psychiatric, community mental health, and case management shall be reimbursed on a fee-for-service basis. Beginning July 1, 2005, such children, who are open for child welfare services in the HomeSafeNet system, shall receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies either through a single agency or formal agreements among several agencies. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan must provide mechanisms to maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children

and Family Services. The agency is authorized to seek any federal waivers to implement this initiative.

(d) A provider service network which may be reimbursed on a fee-for-service or prepaid basis. A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must comply with the solvency requirements in s. 641.2261(2) and meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. ~~The agency shall award contracts on a competitive bid basis and shall select bidders based upon price and quality of care.~~ Medicaid recipients assigned to a provider service network ~~demonstration project~~ shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. Any contract previously awarded to a provider service network operated by a hospital pursuant to this subsection shall remain in effect for a period of 3 years following the current contract expiration date, regardless of any contractual provisions to the contrary. A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the

financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

Section 4. Section 409.91211, Florida Statutes, is amended to read:

409.91211 Medicaid managed care pilot program.--

(1)(a) The agency is authorized to seek experimental, pilot, or demonstration project waivers, pursuant to s. 1115 of the Social Security Act, to create a statewide initiative to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida Medicaid program pursuant to this section. Phase one of the demonstration shall be implemented in two geographic areas. One demonstration site shall include only Broward County. A second demonstration site shall initially include Duval County and shall be expanded to include Baker, Clay, and Nassau Counties within 1 year after the Duval County program becomes operational. This waiver authority is contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program authorized pursuant to this chapter. Under the upper payment limit program, the hospital

disproportionate share program, or the low income pool as implemented by the agency pursuant to federal waiver, the state matching funds required for the program shall be provided by the state and by local governmental entities through intergovernmental transfers. The agency shall distribute funds from the upper payment limit program, the hospital disproportionate share program, and the low income pool according to federal regulations and waivers and the low income pool methodology approved by the Centers for Medicare and Medicaid Services. ~~Upon completion of the evaluation conducted under s. 3, ch. 2005-133, Laws of Florida, the agency may request statewide expansion of the demonstration projects. Statewide phase-in to additional counties shall be contingent upon review and approval by the Legislature.~~

(b) It is the intent of the Legislature that the low income pool plan required by the terms and conditions of the Medicaid reform waiver and submitted to the Centers for Medicare and Medicaid Services propose the distribution of the program funds in paragraph (a) based on the following objectives:

1. Ensure a broad and fair distribution of available funds based on the access provided by Medicaid participating hospitals, regardless of their ownership status, through their delivery of inpatient or outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals.

2. Ensure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals.

3. Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals.

4. Promote teaching and specialty hospital programs.

5. Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals.

6. Recognize the extent of hospital uncompensated care costs.

7. Maintain and enhance essential community hospital care.

8. Maintain incentives for local governmental entities to contribute to the cost of uncompensated care.

9. Promote measures to avoid preventable hospitalizations.

10. Account for hospital efficiency.

11. Contribute to a community's overall health system.

(2) The Legislature intends for the capitated managed care pilot program to:

(a) Provide recipients in Medicaid fee-for-service or the MediPass program a comprehensive and coordinated capitated managed care system for all health care services specified in ss. 409.905 and 409.906.

(b) Stabilize Medicaid expenditures under the pilot program compared to Medicaid expenditures in the pilot area for the 3 years before implementation of the pilot program, while ensuring:

1. Consumer education and choice.

2. Access to medically necessary services.

3. Coordination of preventative, acute, and long-term care.

4. Reductions in unnecessary service utilization.

(c) Provide an opportunity to evaluate the feasibility of statewide implementation of capitated managed care networks as a replacement for the current Medicaid fee-for-service and MediPass systems.

(3) The agency shall have the following powers, duties, and responsibilities with respect to the ~~development of a~~ pilot program:

(a) To implement ~~develop and recommend~~ a system to deliver all mandatory services specified in s. 409.905 and optional services specified in s. 409.906, as approved by the Centers for Medicare and Medicaid Services and the Legislature in the waiver pursuant to this section. Services to recipients under plan benefits shall include emergency services provided under s. 409.9128.

(b) To implement a pilot program that includes ~~recommend~~ Medicaid eligibility categories~~, from those~~ specified in ss. 409.903 and 409.904 as authorized in an approved federal waiver~~, which shall be included in the pilot program~~.

(c) To implement ~~determine and recommend how to design~~ the managed care pilot program that maximizes ~~in order to take maximum advantage of~~ all available state and federal funds, including those obtained through intergovernmental transfers, the low income pool, supplemental Medicaid payments ~~upper-payment-level funding systems~~, and the disproportionate share program. Within the parameters allowed by federal statute and rule, the agency is authorized to seek options for making direct payments to hospitals and physicians employed by or under

contract with the state's medical schools for the costs associated with graduate medical education under Medicaid reform.

(d) To implement ~~determine and recommend~~ actuarially sound, risk-adjusted capitation rates for Medicaid recipients in the pilot program which ~~can be separated to~~ cover comprehensive care, enhanced services, and catastrophic care.

(e) To implement ~~determine and recommend~~ policies and guidelines for phasing in financial risk for approved provider service networks over a 3-year period. These policies and guidelines shall include an option for a provider service network to be paid ~~to pay~~ fee-for-service rates. For any provider service network established in a managed care pilot area, the option to be paid fee-for-service rates shall include a savings-settlement mechanism that is consistent with s. 409.912(44) ~~that may include a savings-settlement option for at least 2 years~~. This model shall ~~may~~ be converted to a risk-adjusted capitated rate no later than the beginning of the fourth ~~in the third~~ year of operation and may be converted earlier at the option of the provider service network. Federally qualified health centers may be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid primary care services.

(f) To implement ~~determine and recommend provisions related to~~ stop-loss requirements and the transfer of excess cost to catastrophic coverage that accommodates the risks associated with the development of the pilot program.

(g) To ~~determine and~~ recommend a process to be used by the Social Services Estimating Conference to determine and validate the rate of growth of the per-member costs of providing Medicaid services under the managed care pilot program.

(h) To implement ~~determine and recommend~~ program standards and credentialing requirements for capitated managed care networks to participate in the pilot program, including those related to fiscal solvency, quality of care, and adequacy of access to health care providers. It is the intent of the Legislature that, to the extent possible, any pilot program authorized by the state under this section include any federally qualified health center, any federally qualified rural health clinic, county health department, the Division of Children's Medical Services Network within the Department of Health, or any other federally, state, or locally funded entity that serves the geographic areas within the boundaries of the pilot program that requests to participate. This paragraph does not relieve an entity that qualifies as a capitated managed care network under this section from any other licensure or regulatory requirements contained in state or federal law which would otherwise apply to the entity. The standards and credentialing requirements shall be based upon, but are not limited to:

1. Compliance with the accreditation requirements as provided in s. 641.512.

2. Compliance with early and periodic screening, diagnosis, and treatment screening requirements under federal law.

3. The percentage of voluntary disenrollments.

4. Immunization rates.

5. Standards of the National Committee for Quality Assurance and other approved accrediting bodies.

6. Recommendations of other authoritative bodies.

7. Specific requirements of the Medicaid program, or standards designed to specifically meet the unique needs of Medicaid recipients.

8. Compliance with the health quality improvement system as established by the agency, which incorporates standards and guidelines developed by the Centers for Medicare and Medicaid Services as part of the quality assurance reform initiative.

9. The network's infrastructure capacity to manage financial transactions, recordkeeping, data collection, and other administrative functions.

10. The network's ability to submit any financial, programmatic, or patient-encounter data or other information required by the agency to determine the actual services provided and the cost of administering the plan.

(i) To implement ~~develop and recommend~~ a mechanism for providing information to Medicaid recipients for the purpose of selecting a capitated managed care plan. For each plan available to a recipient, the agency, at a minimum, shall ensure that the recipient is provided with:

1. A list and description of the benefits provided.

2. Information about cost sharing.

3. Plan performance data, if available.

4. An explanation of benefit limitations.

5. Contact information, including identification of providers participating in the network, geographic locations, and transportation limitations.

6. Any other information the agency determines would facilitate a recipient's understanding of the plan or insurance that would best meet his or her needs.

(j) To implement ~~develop and recommend~~ a system to ensure that there is a record of recipient acknowledgment that choice counseling has been provided.

(k) To implement ~~develop and recommend~~ a choice counseling system to ensure that the choice counseling process and related material are designed to provide counseling through face-to-face interaction, by telephone, and in writing and through other forms of relevant media. Materials shall be written at the fourth-grade reading level and available in a language other than English when 5 percent of the county speaks a language other than English. Choice counseling shall also use language lines and other services for impaired recipients, such as TTD/TTY.

(l) To implement ~~develop and recommend~~ a system that prohibits capitated managed care plans, their representatives, and providers employed by or contracted with the capitated managed care plans from recruiting persons eligible for or enrolled in Medicaid, from providing inducements to Medicaid recipients to select a particular capitated managed care plan, and from prejudicing Medicaid recipients against other capitated managed care plans. The system shall require the entity performing choice counseling to determine if the recipient has

made a choice of a plan or has opted out because of duress, threats, payment to the recipient, or incentives promised to the recipient by a third party. If the choice counseling entity determines that the decision to choose a plan was unlawfully influenced or a plan violated any of the provisions of s. 409.912(21), the choice counseling entity shall immediately report the violation to the agency's program integrity section for investigation. Verification of choice counseling by the recipient shall include a stipulation that the recipient acknowledges the provisions of this subsection.

(m) To implement ~~develop and recommend~~ a choice counseling system that promotes health literacy and provides information aimed to reduce minority health disparities through outreach activities for Medicaid recipients.

(n) To ~~develop and recommend a system for the agency to~~ contract with entities to perform choice counseling. The agency may establish standards and performance contracts, including standards requiring the contractor to hire choice counselors who are representative of the state's diverse population and to train choice counselors in working with culturally diverse populations.

(o) To implement ~~determine and recommend descriptions of the~~ eligibility assignment processes ~~which will be used~~ to facilitate client choice while ensuring pilot programs of adequate enrollment levels. These processes shall ensure that pilot sites have sufficient levels of enrollment to conduct a valid test of the managed care pilot program within a 2-year timeframe.

(p) To implement standards for plan compliance, including, but not limited to, quality assurance and performance improvement standards, peer or professional review standards, grievance policies, and program integrity policies.

(q) To develop a data reporting system, seek input from managed care plans to establish patient-encounter reporting requirements, and ensure that the data reported is accurate and complete.

(r) To work with managed care plans to establish a uniform system to measure and monitor outcomes of a recipient of Medicaid services which shall use financial, clinical, and other criteria based on pharmacy services, medical services, and other data related to the provision of Medicaid services, including, but not limited to:

1. Health Plan Employer Data and Information Set (HEDIS) or HEDIS measures specific to Medicaid.

2. Member satisfaction.

3. Provider satisfaction.

4. Report cards on plan performance and best practices.

5. Compliance with the prompt payment of claims requirements provided in ss. 627.613, 641.3155, and 641.513.

(s) To require managed care plans that have contracted with the agency to establish a quality assurance system that incorporates the provisions of s. 409.912(27) and any standards, rules, and guidelines developed by the agency.

(t) To establish a patient-encounter database to compile data on health care services rendered by health care practitioners that provide services to patients enrolled in

managed care plans in the demonstration sites. Health care practitioners and facilities in the demonstration sites shall submit, and managed care plans participating in the demonstration sites shall receive, claims payment and any other information reasonably related to the patient-encounter database electronically in a standard format as required by the agency. The agency shall establish reasonable deadlines for phasing in the electronic transmittal of full-encounter data. The patient-encounter database shall:

1. Collect the following information, if applicable, for each type of patient encounter with a health care practitioner or facility, including:

a. The demographic characteristics of the patient.

b. The principal, secondary, and tertiary diagnosis.

c. The procedure performed.

d. The date when and the location where the procedure was performed.

e. The amount of the payment for the procedure.

f. The health care practitioner's universal identification number.

g. If the health care practitioner rendering the service is a dependent practitioner, the modifiers appropriate to indicate that the service was delivered by the dependent practitioner.

2. Collect appropriate information relating to prescription drugs for each type of patient encounter.

3. Collect appropriate information related to health care costs and utilization from managed care plans participating in

the demonstration sites. To the extent practicable, the agency shall utilize a standardized claim form or electronic transfer system that is used by health care practitioners, facilities, and payors. ~~To develop and recommend a system to monitor the provision of health care services in the pilot program, including utilization and quality of health care services for the purpose of ensuring access to medically necessary services. This system shall include an encounter data information system that collects and reports utilization information. The system shall include a method for verifying data integrity within the database and within the provider's medical records.~~

(u) ~~(q)~~ To implement ~~recommend~~ a grievance resolution process for Medicaid recipients enrolled in a capitated managed care network under the pilot program modeled after the subscriber assistance panel, as created in s. 408.7056. This process shall include a mechanism for an expedited review of no greater than 24 hours after notification of a grievance if the life of a Medicaid recipient is in imminent and emergent jeopardy.

(v) ~~(r)~~ To implement ~~recommend~~ a grievance resolution process for health care providers employed by or contracted with a capitated managed care network under the pilot program in order to settle disputes among the provider and the managed care network or the provider and the agency.

(w) ~~(s)~~ To implement ~~develop and recommend~~ criteria in an approved federal waiver to designate health care providers as eligible to participate in the pilot program. ~~The agency and capitated managed care networks must follow national guidelines~~

~~for selecting health care providers, whenever available.~~ These criteria must include at a minimum those criteria specified in s. 409.907.

(x) ~~(t)~~ To use ~~develop and recommend~~ health care provider agreements for participation in the pilot program.

(y) ~~(u)~~ To require that all health care providers under contract with the pilot program be duly licensed in the state, if such licensure is available, and meet other criteria as may be established by the agency. These criteria shall include at a minimum those criteria specified in s. 409.907.

(z) ~~(v)~~ To ensure that managed care organizations work collaboratively ~~develop and recommend agreements~~ with other state or local governmental programs or institutions for the coordination of health care to eligible individuals receiving services from such programs or institutions.

(aa) ~~(w)~~ To implement procedures to minimize the risk of Medicaid fraud and abuse in all plans operating in the Medicaid managed care pilot program authorized in this section:

1. The agency shall ensure that applicable provisions of chapters 409, 414, 626, 641, and 932, relating to Medicaid fraud and abuse, are applied and enforced at the demonstration sites.

2. Providers shall have the necessary certification, license, and credentials required by law and federal waiver.

3. The agency shall ensure that the plan is in compliance with the provisions of s. 409.912(21) and (22).

4. The agency shall require each plan to establish program integrity functions and activities to reduce the incidence of

fraud and abuse. Plans must report instances of fraud and abuse pursuant to chapter 641.

5. The plan shall have written administrative and management procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse. The plan shall designate a compliance officer with sufficient experience in health care.

6.a. The agency shall require all managed care plan contractors in the pilot program to report all instances of suspected fraud and abuse. A failure to report instances of suspected fraud and abuse is a violation of law and subject to the penalties provided by law.

b. An instance of fraud and abuse in the managed care plan, including, but not limited to, defrauding the state health care benefit program by misrepresentation of fact in reports, claims, certifications, enrollment claims, demographic statistics, and patient-encounter data; misrepresentation of the qualifications of persons rendering health care and ancillary services; bribery and false statements relating to the delivery of health care; unfair and deceptive marketing practices; and managed care false claims actions, is a violation of law and subject to the penalties provided by law.

c. The agency shall require all contractors to make all files and relevant billing and claims data accessible to state regulators and investigators and all such data shall be linked into a unified system for seamless reviews and investigations. ~~To develop and recommend a system to oversee the activities of pilot program participants, health care providers, capitated~~

~~managed care networks, and their representatives in order to prevent fraud or abuse, overutilization or duplicative utilization, underutilization or inappropriate denial of services, and neglect of participants and to recover overpayments as appropriate. For the purposes of this paragraph, the terms "abuse" and "fraud" have the meanings as provided in s. 409.913. The agency must refer incidents of suspected fraud, abuse, overutilization and duplicative utilization, and underutilization or inappropriate denial of services to the appropriate regulatory agency.~~

(bb) ~~(x)~~ To develop and provide actuarial and benefit design analyses that indicate the effect on capitation rates and benefits offered in the pilot program over a prospective 5-year period based on the following assumptions:

1. Growth in capitation rates which is limited to the estimated growth rate in general revenue.

2. Growth in capitation rates which is limited to the average growth rate over the last 3 years in per-recipient Medicaid expenditures.

3. Growth in capitation rates which is limited to the growth rate of aggregate Medicaid expenditures between the 2003-2004 fiscal year and the 2004-2005 fiscal year.

(cc) ~~(y)~~ To develop a mechanism to require capitated managed care plans to reimburse qualified emergency service providers, including, but not limited to, ambulance services, in accordance with ss. 409.908 and 409.9128. The pilot program must include a provision for continuing fee-for-service payments for emergency services, including, but not limited to, individuals

who access ambulance services or emergency departments and who are subsequently determined to be eligible for Medicaid services.

(dd) ~~(z)~~ To ensure ~~develop a system whereby~~ school districts participating in the certified school match program pursuant to ss. 409.908(21) and 1011.70 shall be reimbursed by Medicaid, subject to the limitations of s. 1011.70(1), for a Medicaid-eligible child participating in the services as authorized in s. 1011.70, as provided for in s. 409.9071, regardless of whether the child is enrolled in a capitated managed care network. Capitated managed care networks must make a good faith effort to execute agreements with school districts regarding the coordinated provision of services authorized under s. 1011.70. County health departments delivering school-based services pursuant to ss. 381.0056 and 381.0057 must be reimbursed by Medicaid for the federal share for a Medicaid-eligible child who receives Medicaid-covered services in a school setting, regardless of whether the child is enrolled in a capitated managed care network. Capitated managed care networks must make a good faith effort to execute agreements with county health departments regarding the coordinated provision of services to a Medicaid-eligible child. To ensure continuity of care for Medicaid patients, the agency, the Department of Health, and the Department of Education shall develop procedures for ensuring that a student's capitated managed care network provider receives information relating to services provided in accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.

(ee) ~~(aa)~~ To implement ~~develop and recommend~~ a mechanism whereby Medicaid recipients who are already enrolled in a managed care plan or the MediPass program in the pilot areas shall be offered the opportunity to change to capitated managed care plans on a staggered basis, as defined by the agency. All Medicaid recipients shall have 30 days in which to make a choice of capitated managed care plans. Those Medicaid recipients who do not make a choice shall be assigned to a capitated managed care plan in accordance with paragraph (4)(a) and shall be exempt from s. 409.9122. To facilitate continuity of care for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a capitated managed care plan, the agency shall determine whether the SSI recipient has an ongoing relationship with a provider or capitated managed care plan, and, if so, the agency shall assign the SSI recipient to that provider or capitated managed care plan where feasible. Those SSI recipients who do not have such a provider relationship shall be assigned to a capitated managed care plan provider in accordance with paragraph (4)(a) and shall be exempt from s. 409.9122.

(ff) ~~(bb)~~ To develop and recommend a service delivery alternative for children having chronic medical conditions which establishes a medical home project to provide primary care services to this population. The project shall provide community-based primary care services that are integrated with other subspecialties to meet the medical, developmental, and emotional needs for children and their families. This project shall include an evaluation component to determine impacts on

hospitalizations, length of stays, emergency room visits, costs, and access to care, including specialty care and patient and family satisfaction.

(gg) ~~(cc)~~ To develop and recommend service delivery mechanisms within capitated managed care plans to provide Medicaid services as specified in ss. 409.905 and 409.906 to persons with developmental disabilities sufficient to meet the medical, developmental, and emotional needs of these persons.

(hh) ~~(dd)~~ To develop and recommend service delivery mechanisms within capitated managed care plans to provide Medicaid services as specified in ss. 409.905 and 409.906 to Medicaid-eligible children in foster care. These services must be coordinated with community-based care providers as specified in s. 409.1675, where available, and be sufficient to meet the medical, developmental, and emotional needs of these children.

(4)(a) A Medicaid recipient in the pilot area who is not currently enrolled in a capitated managed care plan upon implementation is not eligible for services as specified in ss. 409.905 and 409.906, for the amount of time that the recipient does not enroll in a capitated managed care network. If a Medicaid recipient has not enrolled in a capitated managed care plan within 30 days after eligibility, the agency shall assign the Medicaid recipient to a capitated managed care plan based on the assessed needs of the recipient as determined by the agency and shall be exempt from s. 409.9122. When making assignments, the agency shall take into account the following criteria:

1. A capitated managed care network has sufficient network capacity to meet the needs of members.

2. The capitated managed care network has previously enrolled the recipient as a member, or one of the capitated managed care network's primary care providers has previously provided health care to the recipient.

3. The agency has knowledge that the member has previously expressed a preference for a particular capitated managed care network as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4. The capitated managed care network's primary care providers are geographically accessible to the recipient's residence.

(b) When more than one capitated managed care network provider meets the criteria specified in paragraph (3)(h), the agency shall make recipient assignments consecutively by family unit.

(c) If a recipient is currently enrolled with a Medicaid managed care organization that also operates an approved reform plan within a pilot area and the recipient fails to choose a plan during the reform enrollment process or during redetermination of eligibility, the recipient shall be automatically assigned by the agency into the most appropriate reform plan operated by the recipient's current Medicaid managed care organization. If the recipient's current managed care organization does not operate a reform plan in the pilot area that adequately meets the needs of the Medicaid recipient, the agency shall use the auto assignment process as prescribed in the Centers for Medicare and Medicaid Services Special Terms and Conditions number 11-W-00206/4. All agency enrollment and choice

counseling materials shall communicate the provisions of this paragraph to current managed care recipients.

(d) ~~(c)~~ The agency may not engage in practices that are designed to favor one capitated managed care plan over another or that are designed to influence Medicaid recipients to enroll in a particular capitated managed care network in order to strengthen its particular fiscal viability.

(e) ~~(d)~~ After a recipient has made a selection or has been enrolled in a capitated managed care network, the recipient shall have 90 days in which to voluntarily disenroll and select another capitated managed care network. After 90 days, no further changes may be made except for cause. Cause shall include, but not be limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, inordinate or inappropriate changes of primary care providers, service access impairments due to significant changes in the geographic location of services, or fraudulent enrollment. The agency may require a recipient to use the capitated managed care network's grievance process as specified in paragraph (3)(g) prior to the agency's determination of cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged. The grievance process, when used, must be completed in time to permit the recipient to disenroll no later than the first day of the second month after the month the disenrollment request was made. If the capitated managed care network, as a result of the grievance process, approves an enrollee's request to disenroll, the agency is not required to make a determination in the case.

The agency must make a determination and take final action on a recipient's request so that disenrollment occurs no later than the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree with the agency's finding that cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.

(f) ~~(e)~~ The agency shall apply for federal waivers from the Centers for Medicare and Medicaid Services to lock eligible Medicaid recipients into a capitated managed care network for 12 months after an open enrollment period. After 12 months of enrollment, a recipient may select another capitated managed care network. However, nothing shall prevent a Medicaid recipient from changing primary care providers within the capitated managed care network during the 12-month period.

(g) ~~(f)~~ The agency shall apply for federal waivers from the Centers for Medicare and Medicaid Services to allow recipients to purchase health care coverage through an employer-sponsored health insurance plan instead of through a Medicaid-certified plan. This provision shall be known as the opt-out option.

1. A recipient who chooses the Medicaid opt-out option shall have an opportunity for a specified period of time, as authorized under a waiver granted by the Centers for Medicare and Medicaid Services, to select and enroll in a Medicaid-certified plan. If the recipient remains in the employer-sponsored plan after the specified period, the recipient shall

remain in the opt-out program for at least 1 year or until the recipient no longer has access to employer-sponsored coverage, until the employer's open enrollment period for a person who opts out in order to participate in employer-sponsored coverage, or until the person is no longer eligible for Medicaid, whichever time period is shorter.

2. Notwithstanding any other provision of this section, coverage, cost sharing, and any other component of employer-sponsored health insurance shall be governed by applicable state and federal laws.

~~(5) This section does not authorize the agency to implement any provision of s. 1115 of the Social Security Act experimental, pilot, or demonstration project waiver to reform the state Medicaid program in any part of the state other than the two geographic areas specified in this section unless approved by the Legislature.~~

(5)~~(6)~~ The agency shall develop and submit for approval applications for waivers of applicable federal laws and regulations as necessary to implement the managed care pilot project as defined in this section. The agency shall post all waiver applications under this section on its Internet website 30 days before submitting the applications to the United States Centers for Medicare and Medicaid Services. All waiver applications shall be provided for review and comment to the appropriate committees of the Senate and House of Representatives for at least 10 working days prior to submission. All waivers submitted to and approved by the United States Centers for Medicare and Medicaid Services under this

section must be approved by the Legislature. Federally approved waivers must be submitted to the President of the Senate and the Speaker of the House of Representatives for referral to the appropriate legislative committees. The appropriate committees shall recommend whether to approve the implementation of any waivers to the Legislature as a whole. The agency shall submit a plan containing a recommended timeline for implementation of any waivers and budgetary projections of the effect of the pilot program under this section on the total Medicaid budget for the 2006-2007 through 2009-2010 state fiscal years. This implementation plan shall be submitted to the President of the Senate and the Speaker of the House of Representatives at the same time any waivers are submitted for consideration by the Legislature. The agency is authorized to implement the waiver and Centers for Medicare and Medicaid Services Special Terms and Conditions number 11-W-00206/4. If the agency seeks approval by the Federal Government of any modifications to these special terms and conditions, the agency shall provide written notification of its intent to modify these terms and conditions to the President of the Senate and Speaker of the House of Representatives at least 15 days prior to submitting the modifications to the Federal Government for consideration. The notification shall identify all modifications being pursued and the reason they are needed. Upon receiving federal approval of any modifications to the special terms and conditions, the agency shall report to the Legislature describing the federally approved modifications to the special terms and conditions within 7 days after their approval by the Federal Government.

(6)~~(7)~~ Upon review and approval of the applications for waivers of applicable federal laws and regulations to implement the managed care pilot program by the Legislature, the agency may initiate adoption of rules pursuant to ss. 120.536(1) and 120.54 to implement and administer the managed care pilot program as provided in this section and the agency shall initiate adoption of rules pursuant to ss. 120.536(1) and 120.54 to develop, implement, and administer the following provisions of the managed care pilot program:

(a) Risk-adjusted capitation rates pursuant to paragraph (3)(d).

(b) A mechanism for providing information to Medicaid recipients pursuant to paragraph (3)(i).

(c) A choice counseling system pursuant to paragraphs (3)(k), (l), and (m).

(7)(a) The Office of Insurance Regulation shall provide ongoing guidance to the agency in the implementation of risk-adjusted rates. Beginning on the effective date of this act, the Office of Insurance Regulation shall make advisory recommendations to the agency regarding the following items:

1. The methodology adopted by the agency for risk-adjusted rates, including any suggestions to improve the predictive value of the system.

2. Alternative options based on the agency's methodology.

3. The risk-adjusted rate for each Medicaid eligibility category in the demonstration program.

4. Administrative and implementation issues regarding the use of risk-adjusted rates, including, but not limited to, cost, simplicity, client privacy, data accuracy, and data exchange.

5. The appropriateness of phasing in risk-adjusted rates.

(b) As a part of this process, the Office of Insurance Regulation shall contract with an independent actuary firm to assist in the annual review and to provide technical expertise.

(c) As a part of this process, the agency shall solicit input concerning the agency's rate setting methodology from the Florida Association of Health Plans, the Florida Hospital Association, the Florida Medical Association, Medicaid recipient advocacy groups, and other stakeholder representatives as necessary to obtain a broad representation of perspectives on the effects of the agency's adopted rate setting methodology and recommendations on possible modifications to the methodology.

(d) The Office of Insurance Regulation shall submit a report of its findings and advisory recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives prior to the implementation of risk-adjusted rates on July 1, 2006, and annually thereafter no later than February 1 of each year for consideration by the Legislature for inclusion in the General Appropriations Act.

(8) Any provision of law to the contrary notwithstanding, adjustments to risk-adjusted capitation rates shall be implemented through rules of the agency, as required by s. 409.9124, based upon the recommendation of the committee.

(9) The capitation rates for plans participating under this section shall be phased in as follows:

(a) In the first fiscal year, the capitation rates shall be weighted so that 75 percent of each capitation rate is based upon the current methodology and 25 percent is based upon a new risk-adjusted capitation rate methodology.

(b) In the second fiscal year, the capitation rates shall be weighted so that 50 percent of each capitation rate is based upon the current methodology and 50 percent is based upon a new risk-adjusted rate methodology.

(c) In the third fiscal year, the capitation rates shall be weighted so that 25 percent of each capitation rate is based upon the current methodology and 75 percent is based upon a new risk-adjusted capitation rate methodology.

(d) In the following fiscal year, the risk-adjusted capitation rate methodology may be fully implemented.

(10) The agency must ensure the following when using a risk-adjustment rate methodology in whole or part:

(a) The agency's total annual payment shall be based on each managed care plan's own aggregate risk score, except that in no case shall the aggregate risk score of any managed care plan in an area vary by more than 10 percent from the aggregate weighted mean of all managed care plans providing comprehensive benefits to TANF and SSI recipients in that area. The agency's total annual payment to a managed care plan shall be based on such revised aggregate risk score.

(b) After any adjustments required pursuant to paragraph (a), the aggregate payments calculated to be made to managed care plans on behalf of enrollees in any pilot area must be no less than what the aggregate payments would have been using the

current rate methodology under s. 409.9124. If the agency determines that such aggregate payments under the risk-adjusted methodology will be lower than the aggregate payments that the plans would have been paid using the current rate methodology under s. 409.9124, supplemental payments shall be made to managed care plans so that the proportion of overall revenue remains the same on an aggregate basis per plan. Such supplemental payments shall be made to bring total payments up to the amount that would have been paid under s. 409.9124.

(11) Prior to the implementation of risk-adjusted capitation rates, the rates shall be certified by an actuary and approved by the Centers for Medicare and Medicaid Services.

(12) For purposes of this section, the term "capitated managed care plan" includes health insurers authorized under chapter 624, exclusive provider organizations authorized under chapter 627, health maintenance organizations authorized under chapter 641, and provider service networks that elect to be paid fee-for-service for up to 3 years as authorized under this section.

Section 5. Section 409.91212, Florida Statutes, is created to read:

409.91212 Medicaid reform demonstration program expansion.--

(1) The agency may expand the Medicaid reform demonstration program pursuant to s. 409.91211 into any county of the state beginning in year two of the demonstration program if readiness criteria are met, the Joint Legislative Committee on Medicaid Reform Implementation has submitted a recommendation

pursuant to s. 11.72 regarding the extent to which the criteria have been met, and the agency has secured budget approval from the Legislative Budget Commission pursuant to s. 11.90. For the purpose of this section, the term "readiness" means there is evidence that at least two programs in a county meet the following criteria:

(a) Demonstrate knowledge and understanding of managed care under the framework of Medicaid reform.

(b) Demonstrate financial capability to meet solvency standards.

(c) Demonstrate adequate controls and process for financial management.

(d) Demonstrate the capability for clinical management of Medicaid recipients.

(e) Demonstrate the adequacy, capacity, and accessibility of the services network.

(f) Demonstrate the capability to operate a management information system and an encounter data system.

(g) Demonstrate capability to implement quality assurance and utilization management activities.

(h) Demonstrate capability to implement fraud control activities.

(2) The agency shall conduct meetings and public hearings in the targeted expansion county with the public and provider community. The agency shall provide notice regarding public hearings. The agency shall maintain records of the proceedings.

(3) The agency shall provide a 30-day notice of intent to expand the demonstration program with supporting documentation

that the readiness criteria has been met to the President of the Senate, the Speaker of the House of Representatives, the Minority Leader of the Senate, the Minority Leader of the House of Representatives, and the Office of Program Policy Analysis and Government Accountability.

(4) The agency shall request a hearing and consideration by the Joint Legislative Committee on Medicaid Reform Implementation after the 30-day notice required in subsection (3) has expired in the form of a letter to the chair of the committee.

(5) Upon receiving a memorandum from the Joint Legislative Committee on Medicaid Reform Implementation regarding the extent to which the expansion criteria pursuant to subsection (1) have been met, the agency may submit a budget amendment, pursuant to chapter 216, to request the necessary budget transfers associated with the expansion of the demonstration program.

Section 6. Subsections (8) through (14) of section 409.9122, Florida Statutes, are renumbered as subsections (7) through (13), respectively, and paragraphs (e), (f), (g), (h), (k), and (l) of subsection (2) and present subsection (7) of that section are amended to read:

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.--

(2)

(e) ~~Medicaid recipients who are already enrolled in a managed care plan or MediPass shall be offered the opportunity to change managed care plans or MediPass providers on a staggered basis, as defined by the agency.~~ All Medicaid

recipients shall have 30 days in which to make a choice of managed care plans or MediPass providers. ~~Those Medicaid recipients who do not make a choice shall be assigned to a managed care plan or MediPass in accordance with paragraph (f). To facilitate continuity of care, for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a managed care plan or MediPass, the agency shall determine whether the SSI recipient has an ongoing relationship with a MediPass provider or managed care plan, and if so, the agency shall assign the SSI recipient to that MediPass provider or managed care plan. Those SSI recipients who do not have such a provider relationship shall be assigned to a managed care plan or MediPass provider in accordance with paragraph (f).~~

(f) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan ~~or MediPass provider~~. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans ~~until an enrollment of 40 percent in MediPass and 60 percent in managed care plans is achieved~~. ~~Once this enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 40 percent and 60 percent proportion, respectively. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an~~

~~update of the preferences of Medicaid recipients. The agency shall disproportionately assign Medicaid-eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass, including children, and who are to be assigned to the MediPass program to children's networks as described in s. 409.912(4)(g), Children's Medical Services Network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate, until the agency has determined that the networks and programs have sufficient numbers to be economically operated.~~ For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

1. A managed care plan has sufficient network capacity to meet the need of members.

2. The managed care plan ~~or MediPass~~ has previously enrolled the recipient as a member, or one of the managed care plan's primary care providers ~~or MediPass providers~~ has previously provided health care to the recipient.

3. The agency has knowledge that the member has previously expressed a preference for a particular managed care plan or MediPass provider as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4. The managed care plan is ~~plan's or MediPass primary care providers are~~ geographically accessible to the recipient's residence.

5. The agency has authority to make mandatory assignments based on quality of service and performance of managed care plans.

(g) When more than one managed care plan ~~or MediPass provider~~ meets the criteria specified in paragraph (f), the agency shall make recipient assignments consecutively by family unit.

(h) The agency may not engage in practices that are designed to favor one managed care plan over another ~~or that are designed to influence Medicaid recipients to enroll in MediPass rather than in a managed care plan or to enroll in a managed care plan rather than in MediPass~~. This subsection does not prohibit the agency from reporting on the performance of MediPass or any managed care plan, as measured by performance criteria developed by the agency.

~~(k) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid~~

~~recipients in counties with fewer than two managed care plans accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 40 percent in MediPass and 60 percent in managed care plans is achieved. Once that enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 40 percent and 60 percent proportion, respectively. In service areas 1 and 6 of the Agency for Health Care Administration where the agency is contracting for the provision of comprehensive behavioral health services through a capitated prepaid arrangement, recipients who fail to make a choice shall be assigned equally to MediPass or a managed care plan. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider organizations, provider service networks, Children's Medical Services Network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:~~

~~1. A managed care plan has sufficient network capacity to meet the need of members.~~

~~2. The managed care plan or MediPass has previously enrolled the recipient as a member, or one of the managed care plan's primary care providers or MediPass providers has previously provided health care to the recipient.~~

~~3. The agency has knowledge that the member has previously expressed a preference for a particular managed care plan or MediPass provider as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.~~

~~4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.~~

~~5. The agency has authority to make mandatory assignments based on quality of service and performance of managed care plans.~~

(k) ~~(l)~~ Notwithstanding the provisions of chapter 287, the agency may, at its discretion, renew cost-effective contracts for choice counseling services once or more for such periods as the agency may decide. However, all such renewals may not combine to exceed a total period longer than the term of the original contract.

~~(7) The agency shall investigate the feasibility of developing managed care plan and MediPass options for the following groups of Medicaid recipients:~~

~~(a) Pregnant women and infants.~~

~~(b) Elderly and disabled recipients, especially those who are at risk of nursing home placement.~~

~~(c) Persons with developmental disabilities.~~

~~(d) Qualified Medicare beneficiaries.~~

~~(e) Adults who have chronic, high-cost medical conditions.~~

~~(f) Adults and children who have mental health problems.~~

~~(g) Other recipients for whom managed care plans and MediPass offer the opportunity of more cost-effective care and greater access to qualified providers.~~

Section 7. The Agency for Health Care Administration shall report to the Legislature by April 1, 2006, the specific preimplementation milestones required by the Centers for Medicare and Medicaid Services Special Terms and Conditions related to the low income pool that have been approved by the Federal Government and the status of any remaining preimplementation milestones that have not been approved by the Federal Government.

Section 8. Quarterly progress and annual reports.--The Agency for Health Care Administration shall submit to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Minority Leader of the Senate, the Minority Leader of the House of Representatives, and the Office of Program Policy Analysis and Government Accountability the following reports:

(1) Quarterly progress reports submitted to Centers for Medicare and Medicaid Services no later than 60 days following the end of each quarter. These reports shall present the agency's analysis and the status of various operational areas. The quarterly progress reports shall include, but are not limited to, the following:

(a) Documentation of events that occurred during the quarter or that are anticipated to occur in the near future that affect health care delivery, including, but not limited to, the approval of contracts with new managed care plans, the

procedures for designating coverage areas, the process of phasing in managed care, a description of the populations served and the benefits provided, the number of recipients enrolled, a list of grievances submitted by enrollees, and other operational issues.

(b) Action plans for addressing policy and administrative issues.

(c) Documentation of agency efforts related to the collection and verification of encounter and utilization data.

(d) Enrollment data for each managed care plan according to the following specifications: total number of enrollees, eligibility category, number of enrollees receiving Temporary Assistance for Needy Families or Supplemental Security Income, market share, and percentage change in enrollment. In addition, the agency shall provide a summary of voluntary and mandatory selection rates and disenrollment data. Enrollment data, number of members by month, and expenditures shall be submitted in the format for monitoring budget neutrality provided by the Centers for Medicare and Medicaid Services.

(e) Documentation of low income pool activities and associated expenditures.

(f) Documentation of activities related to the implementation of choice counseling including efforts to improve health literacy and the methods used to obtain public input including recipient focus groups.

(g) Participation rates in the Enhanced Benefit Accounts Program, as established in the Centers for Medicare and Medicaid Services Special Terms and Conditions number 11-W-00206/4, which

shall include: participation levels, summary of activities and associated expenditures, number of accounts established including active participants and individuals who continue to retain access to funds in an account but no longer actively participate, estimated quarterly deposits in accounts, and expenditures from the accounts.

(h) Enrollment data on employer-sponsored insurance that documents the number of individuals selecting to opt out when employer-sponsored insurance is available. The agency shall include data that identifies enrollee characteristics to include eligibility category, type of employer-sponsored insurance, and type of coverage based on whether the coverage is for the individual or the family. The agency shall develop and maintain disenrollment reports specifying the reason for disenrolling in an employer-sponsored insurance program. The agency shall also track and report on those enrollees who elect to reenroll in the Medicaid reform waiver demonstration program.

(i) Documentation of progress toward the demonstration program goals.

(j) Documentation of evaluation activities.

(2) The annual report shall document accomplishments, program status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Medicaid reform waiver demonstration program. The agency shall submit the draft annual report no later than October 1 after the end of each fiscal year.

(a) Beginning with the annual report for demonstration program year two, the agency shall include a section on the

administration of enhanced benefit accounts, participation rates, an assessment of expenditures, and potential cost savings.

(b) Beginning with the annual report for demonstration program year four, the agency shall include a section that provides qualitative and quantitative data that describes the impact of the low income pool on the number of uninsured persons in the state from the start of the implementation of the demonstration program.

Section 9. Section 11.72, Florida Statutes, is created to read:

11.72 Joint Legislative Committee on Medicaid Reform Implementation; creation; membership; powers; duties.--

(1) There is created a standing joint committee of the Legislature designated the Joint Legislative Committee on Medicaid Reform Implementation for the purpose of reviewing policy issues related to expansion of the Medicaid managed care pilot program pursuant to s. 409.91211.

(2) The Joint Legislative Committee on Medicaid Reform Implementation shall be composed of eight members appointed as follows: four members of the House of Representatives appointed by the Speaker of the House of Representatives, one of whom shall be a member of the minority party; and four members of the Senate appointed by the President of the Senate, one of whom shall be a member of the minority party. The President of the Senate shall appoint the chair in even-numbered years and the vice chair in odd-numbered years, and the Speaker of the House of Representatives shall appoint the chair in odd-numbered years

and the vice chair in even-numbered years from among the committee membership. Vacancies shall be filled in the same manner as the original appointment. Members shall serve without compensation, except that members are entitled to reimbursement for per diem and travel expenses in accordance with s. 112.061.

(3) The committee shall be governed by joint rules of the Senate and the House of Representatives which shall remain in effect until repealed or amended by concurrent resolution.

(4) The committee shall meet at the call of the chair. The committee may hold hearings on matters within its purview which are in the public interest. A quorum shall consist of a majority of members from each house, plus one additional member from either house. Action by the committee requires a majority vote of the members present of each house.

(5) The committee shall be jointly staffed by the appropriations and substantive committees of the House of Representatives and the Senate. During even-numbered years the Senate shall serve as lead staff and during odd-numbered years the House of Representatives shall serve as lead staff.

(6) The committee shall:

(a) Review reports, public hearing proceedings, documents, and materials provided by the Agency for Health Care Administration relating to the expansion of the Medicaid managed care pilot program to other counties of the state pursuant to s. 409.91212.

(b) Consult with the substantive and fiscal committees of the House of Representatives and the Senate which have

jurisdiction over the Medicaid matters relating to agency action to expand the Medicaid managed care pilot program.

(c) Meet to consider and make a recommendation regarding the extent to which the expansion criteria pursuant to s. 409.91212 have been met.

(7) Within 2 days after meeting, during which the committee reviewed documents, material, and testimony related to the expansion criteria, the committee shall submit a memorandum to the Speaker of the House of Representatives, the President of the Senate, the Legislative Budget Commission, and the agency delineating the extent to which the agency met the expansion criteria.

Section 10. It is the intent of the Legislature that if any conflict exists between the provisions contained in s. 409.91211, Florida Statutes, and other provisions of chapter 409, Florida Statutes, as they relate to implementation of the Medicaid managed care pilot program, the provisions contained in s. 409.91211, Florida Statutes, shall control. The Agency for Health Care Administration shall provide a written report to the President of the Senate and the Speaker of the House of Representatives by April 1, 2006, identifying any provisions of chapter 409, Florida Statutes, that conflict with the implementation of the Medicaid managed care pilot program as created in s. 409.91211, Florida Statutes. After April 1, 2006, the agency shall provide a written report to the President of the Senate and the Speaker of the House of Representatives immediately upon identifying any provisions of chapter 409, Florida Statutes, that conflict with the implementation of the

Medicaid managed care pilot program as created in s. 409.91211, Florida Statutes.

Section 11. Section 216.346, Florida Statutes, is amended to read:

216.346 Contracts between state agencies; restriction on overhead or other indirect costs.--In any contract between state agencies, including any contract involving the State University System or the Florida Community College System, the agency receiving the contract or grant moneys shall charge no more than a reasonable percentage ~~5 percent~~ of the total cost of the contract or grant for overhead or indirect costs or any other costs not required for the payment of direct costs. This provision is not intended to limit an agency's ability to certify matching funds or designate in-kind contributions which will allow the drawdown of federal Medicaid dollars that do not affect state budgeting.

Section 12. One full-time equivalent position is authorized and the sum of $250,000 is appropriated for fiscal year 2006-2007 from the General Revenue Fund to the Office of Insurance Regulation of the Financial Services Commission to fund the annual review of the Medicaid managed care pilot program's risk-adjusted rate setting methodology.

Section 13. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 47B Appropriation to Compensate Wilton Dedge
SPONSOR(S): Goodlette and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 12B

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Fiscal Council		Overton	Kelly
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

Wilton Dedge was convicted of burglary with assault, sexual battery with a weapon, and aggravated battery and imprisoned for 22 years. During that time he was convicted twice: his first conviction was reversed and remanded. His second trial resulted in a conviction that was upheld on appeal. Wilton Dedge was released from imprisonment in 2004 based on DNA evidence that excluded him as the perpetrator of the crimes. In the 2005 session of the Legislature, attempts to compensate Wilton Dedge did not pass.

Wilton Dedge has filed suit against the State of Florida and James Crosby, the Secretary of the Florida Department of Corrections, alleging both tort and constitutional violations (see section entitled 'Pending Lawsuit' in the Effect of Proposed Changes section herein). The Second Circuit Court dismissed the claim, acknowledging that "while everyone is in agreement that what happened to Wilton Dedge is tragic, only the Legislature can address the issue of compensation under existing law." The ruling of the Second Circuit Court was appealed by Mr. Dedge in the First District Court of Appeal, and was dismissed on jurisdictional grounds on November 29, 2005.

This bill appropriates $ 2 million from the General Revenue Fund to compensate Wilton Dedge under the following conditions:

- Delivery of an executed release and waiver of all present and future claims against the state of Florida, and any agency, instrumentality, officer, employee, or political subdivision thereof; and
- An order dismissing Mr. Dedge's current legal case with prejudice.

The authority of the Chief Financial Officer to draw a warrant to compensate Wilton Dedge expires on March 6, 2006. The bill requires that the $2 million be paid to the State Board of Administration, which will distribute the funds as provided in a letter of agreement between Wilton Dedge and his parents and the State Board of Administration. The bill also requires that health care insurance be provided at Mr. Dedge's expense, and that he be provided access to state education programs on a scholarship basis.

The award is intended to provide compensation for any and all present and future claims arising out of the factual situation in connection with Wilton Dedge's conviction and imprisonment. The bill provides that no further award will be made by the state. The bill also provides that the defense of sovereign immunity is not waived by the act.

The act also expresses legislative intent that compensation is based on a moral desire to acknowledge Wilton Dedge's actual innocence, and not on a recognition of a constitutional right or violation, and makes an apology on behalf of the state.

The bill provides for a conditional appropriation of $2 million to be paid out of the General Revenue Fund.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:
Provide limited government – this bill affirms that it is the constitutional role of the Legislature to appropriate state funds.

B. EFFECT OF PROPOSED CHANGES:

Wilton Dedge - In January, 1982, Wilton Dedge was arrested and ultimately adjudicated guilty of burglary with assault, two counts of sexual battery, and aggravated battery. Those judgments were reversed and remanded based on trial court errors regarding the disqualification of an expert witness and improper admission of hearsay evidence.[1] Upon remand, Wilton Dedge was again convicted. That conviction was affirmed on appeal.[2] He was sentenced to two concurrent life sentences, plus consecutive 15-year sentences.

Ten years after his convictions, Wilton Dedge filed a motion pursuant to Florida Rule of Criminal Procedure 3.850[3] seeking DNA testing. The trial court denied that motion as time-barred, which was affirmed on appeal.[4] Mr. Dedge then filed a motion for release of DNA evidence, which motion was granted. Mr. Dedge then filed another 3.850 motion arguing that the DNA test results constituted newly discovered evidence which established that he was not guilty. The trial court denied the motion as time-barred, which was also affirmed on appeal.[5]

Ultimately the State moved for Y-Chromosome testing which was granted by order of the court. That test excluded Wilton Dedge as the perpetrator of the crimes. The Eighteenth Circuit Court in Brevard County granted the State's 3.850 motion to dismiss the charges and to discharge Mr. Dedge from custody on August 11, 2004.[6] He was released the following day, after spending 22 years in prison.

Pending Lawsuit – Following his release, Wilton Dedge sought compensation from the Legislature in the 2005 session. Both chambers filed bills which attempted to create a policy under which the wrongfully incarcerated would be compensated. Both bills ultimately failed.[7]

Wilton Dedge and his parents then petitioned the circuit court for declaratory relief, equitable relief, damages, and expungement of his record. The request for damages included damages for taking of Mr. Dedge's liberty and for wrongful imprisonment, damages for the taking of Mr. Dedge's property interests, damages for the state's unjust enrichment resulting from his provision of services to the state without compensation, and damages for his parents who paid for his legal defense.[8] The Second Circuit court dismissed the petition, making the following findings:

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[1] Dedge v. State, 442 So.2d 429 (Fla. 5th DCA 1983).
[2] Dedge v. State, 479 So.2d 882 (Fla. 5th DCA 1985). The judgments were affirmed on all points, but the minimum mandatory portions of Dedge's sexual battery sentences were reversed and remanded for the trial court to delete the minimum mandatory provisions.
[3] Rule 3.850 of the Florida Rules of Criminal Procedure allows a person to claim that judgment was entered or that the sentence was imposed in violation of the Constitution or laws of the United States or of Florida, that the court was without jurisdiction to enter the judgment or to impose the sentence, that the sentence was in excess of the maximum authorized by law, that the plea was given involuntarily, or that the judgment or sentence is otherwise subject to collateral attack. Such prisoner may move that the sentence be vacated, set aside, or corrected. The motion must be filed within two years after the judgment and sentence became final in non-capital cases. There are enumerated exceptions to the time limitation, none of which were found to apply in Mr. Dedge's case.
[4] Dedge v. State, 723 So.2d 322 (Fla. 5th DCA 1998).
[5] Facts recited in Dedge v. State, 832 So.2d 835, 836 (Fla. 5th DCA 2002).
[6] Order, Case No. 05-1982-00135, Eighteenth Judicial Circuit, August 11, 2004. Based on the earlier denials of Mr. Dedge's 3.850 motions as time-barred, it would appear that Mr. Dedge's release on the instant 3.850 motion was granted based on the joint nature of the motion, rather than a strict application of the rule.
[7] HCR 1879 and CS/CS/SB 1964 (second engrossed).
[8] Wilton Dedge, Walter Gary Dedge, Sr., and Mary Dedge v. James Crosby, Secretary of the Department of Corrections, and the State of Florida, Petition for the Expungement of Record, Factual Findings and other Relief Including Actions for Declaratory Relief and

- Wilton Dedge's parents have no standing to recover damages suffered by their adult child under existing Florida law;
- Wilton Dedge failed to comply with Florida statutes relating to the expunction of Mr. Dedge's criminal records;[9]
- Wilton Dedge's claims for damages are banned by sovereign immunity;
- Wilton Dedge seeks to have the court rule on matters which are clearly the province of the legislative branch of government, not the judicial branch; and
- Only the Legislature can address the issue of compensation under existing law.[10]

The order dismissing the petition was appealed to the First District Court of Appeal,[11] and was dismissed for lack of jurisdiction on November 29, 2005.[12] Mr. Dedge made two arguments on appeal: 1) the trial court erred in holding that there is no judicial remedy for the wrongful taking of liberty; and 2) the trial court erred in dismissing the claim of Walter and Mary Dedge (Wilton Dedge's parents).

Compensation – This bill acknowledges that Mr. Dedge incurred significant losses as a result of his conviction and physical confinement, that he provided valuable services for the state while imprisoned, and that his parents incurred significant expenses related to his legal defense. The bill expresses legislative intent that compensation provided is based on a moral desire to acknowledge his actual innocence, and not on a recognition of a constitutional right or violation. The bill also issues an apology to Wilton Dedge on behalf of the state.

The bill appropriates $2 million from the General Revenue Fund to be paid to the State Board of Administration and authorizes the Chief Financial Officer (CFO) to draw a warrant upon funds in the State Treasury. After March 6, 2006, the CFO is no longer authorized to draw the warrant.

The warrant is payable to the State Board of Administration upon delivery by Wilton Dedge to the CFO, the State Board of Administration, the President of the Senate, and the Speaker of the House of Representatives of all of the following:

- An executed release and waiver on behalf of Wilton Dedge, and his parents, heirs, successors, and assigns, forever releasing the State of Florida and any agency, instrumentality, officer, employee, or political subdivision thereof, or any other entity subject to the provisions of s. 768.28, Florida Statutes, from any and all present or future claims arising out of the factual situation in connection with the conviction for which compensation is awarded; and
- An order from the court having jurisdiction over the legal claim dismissing the claim with prejudice.[13]

The State Board of Administration is directed to distribute funds to Mr. Dedge in accordance with the letter of agreement between the Wilton Dedge, his parents, and the State Board of Administration. The bill requires the State Board of Administration, the State Division of Retirement, and the State Department of Management Services to provide such support and assistance as directed by the terms of the letter of agreement, and are authorized and directed to provide for health care insurance, including mental health and dental coverage for Wilton Dedge, at his expense. The bill also requires that Mr. Dedge be provided access to state education programs on a scholarship basis without tuition

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Damages and Equitable Relief under Extraordinary Writ Authority; filed in the Eighteenth Circuit Court and transferred to the Second Circuit Court, case no. 37 2005 CA 001807, filed in June 2005.

[9] Section 943.0585, F.S.

[10] Dedge et al v. Crosby and State, Order Granting Amended Motion to Dismiss, Second Circuit Court, case no. 2005-CA-001807, filed August 29, 2005.

[11] Dedge et al v. Crosby and State, First District Court of Appeal, case no. 1D05-4288.

[12] Dismissal for lack of jurisdiction based on the non-final nature of the underlying trial court order.

[13] The term "dismissal with prejudice" generally means that the dismissal is conclusive of the rights of the parties as if the action had been prosecuted to final adjudication adverse to the plaintiff. Black's Law Dictionary, 5th Edition, p. 1438.

or fees, provided that he is required to meet and maintain the regular admission requirements of, and be registered at, such state educational program.

The bill provides that passage of this act shall not be deemed to waive the defense of sovereign immunity, nor to increase the statutory limits of liability. Further, the bill is intended to provide sole compensation for any and all present and future claims arising out of the factual situation in connection with Wilton Dedge's conviction and imprisonment.

The act takes effect upon becoming a law.

C. SECTION DIRECTORY:

Section 1 provides that the facts stated in the preamble are found and declared to be true.

Section 2 appropriates $2 million from the General Revenue Fund.

Section 3 directs the Chief Financial Officer to draw the warrant to the State Board of Administration, which is directed to disburse the funds in accordance with the specified letter of agreement. Section 3 also directs that health care insurance be provided as specified, and that access to state educational programs be provided.

Section 4 requires the State Board of Administration to disburse the funds upon delivery of an executed release and waiver of governmental liability, and an order of dismissal with prejudice.

Section 5 provides that the Legislature is not deemed to have waived any defense of sovereign immunity or to have increased the limits of liability.

Section 6 provides that the award is intended to provide sole compensation for any and all present and future claims.

Section 7 provides that the act shall become effective upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   This bill authorizes the payment of $2 million out of the General Revenue Fund, if specific conditions are met.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable because this bill does not appear to require the counties or cities to spend funds or take an action requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

Suits Against the State – Article X, section 13 of the Florida Constitution provides that, "Provision may be made by general law for bringing suit against the state as to all liabilities now existing or hereafter originating." If passed, this bill would be a general law.

Separation of Powers – Article II, section 3 of the Florida Constitution provides that, "No person belonging to one branch shall exercise any powers appertaining to either of the other branches unless expressly provided herein." By acting upon its unique constitutional authority to make appropriations,[14] the Legislature expresses its intent that compensation of Wilton Dedge belongs squarely within the Legislature's constitutional authority. The bill further adheres to the Separation of Powers doctrine by requiring the dismissal of any pending court case prior to making the appropriation, thus avoiding a legislative encroachment in an ongoing judicial matter.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The date on line 97 should be "March 6, 2006" rather than "2005."

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

[14] The power to appropriate state funds is legislative and to be exercised only through duly enacted statutes. Chiles v. Children A, B, C, D, E, and F, 589 So.2d 260 (Fla. 1991) and Article VII, section 1(c) of the Florida Constitution which provides that "no money shall be drawn from the treasury except in pursuance of appropriation made by law."

A bill to be entitled

An act providing an appropriation to compensate Wilton Dedge; providing authority to draw warrant; providing a limitation on the authority to draw the warrant; requiring a specified distribution of funds; providing a condition for payment; providing legislative intent; providing an effective date.

WHEREAS, Wilton Dedge was convicted of rape and imprisoned for 22 years, and

WHEREAS, the initial conviction was appealed and reversed, and

WHEREAS, on retrial Wilton Dedge was again convicted, which conviction was affirmed on appeal, and

WHEREAS, the Circuit Court in the Eighteenth Judicial Circuit granted the state's motion to dismiss pending charges and discharge Wilton Dedge from custody based on DNA evidence that excluded Wilton Dedge as the perpetrator of the crime, and

WHEREAS, Wilton Dedge was in fact released on August 12, 2004, and

WHEREAS, Wilton Dedge and his parents filed suit in the Second Judicial Circuit requesting, among other things, a declaratory judgment that Mr. Dedge's liberty was taken by the government without compensation and requesting damages for the taking of Mr. Dedge's liberty and property, and

WHEREAS, the suit was dismissed by order of the Second Judicial Circuit court, which found that Mr. Dedge's parents have no standing to recover damages suffered by an adult child,

that claims for damages from the state are banned by the doctrine of sovereign immunity, and that only the Legislature can address the issue of compensation under existing law, and

WHEREAS, Wilton Dedge has appealed the order to the First District Court of Appeal, Case No. 1D05-4288, which appeal is pending, and

WHEREAS, the Legislature recognizes that no system of justice is impervious to human error. "Given the myriad safeguards provided to assure a fair trial, and taking into account the reality of the human fallibility of the participants, there can be no such thing as an error-free, perfect trial, and ... the Constitution does not guarantee such a trial." United States v. Hasting, 461 U.S. 499(1983), and

WHEREAS, the Legislature acknowledges that the state's system of justice yielded an imperfect result with tragic consequences in this case, and

WHEREAS, the Legislature acknowledges that Wilton Dedge incurred significant losses unique to Wilton Dedge as a result of his conviction and physical confinement and that all the losses flowed from the fact that he was physically restrained and prevented from exercising the freedom to which all innocent citizens are entitled, and

WHEREAS, the Legislature acknowledges that Wilton Dedge performed valuable services for the state while imprisoned, including serving as a licensed waste-water plant operator, and

WHEREAS, the Legislature acknowledges that Wilton Dedge's parents incurred significant expenses related to his defense and

related to the prolonged efforts to establish his innocence and secure his release from prison, and

WHEREAS, the Legislature is providing compensation to Wilton Dedge to acknowledge the fact that he suffered significant damages unique to Wilton Dedge which resulted from his physical restraint and the deprivation of freedom, and

WHEREAS, the Legislature is providing compensation to Wilton Dedge based on a moral desire to acknowledge his undisputed and actual innocence and not on a recognition of a constitutional right or violation, and

WHEREAS, the Legislature intends that compensation made pursuant to this act shall be the sole compensation to be provided by the state for any and all present and future claims arising out of the factual situation in connection with Wilton Dedge's conviction and imprisonment, and

WHEREAS, the Legislature apologizes to Wilton Dedge on behalf of the state, NOW, THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. The facts stated in the preamble to this act are found and declared to be true.

Section 2. There is appropriated from the General Revenue Fund the sum of $2,000,000 to be paid to Wilton Dedge under the conditions provided in this act.

Section 3. The Chief Financial Officer is directed to draw a warrant to the State Board of Administration in the sum of $2,000,000 for the purposes provided in this act, the funds to

be distributed in accordance with the letter of agreement between Wilton Dedge, Mr. and Mrs. Walter Gary Dedge, Sr., and the State Board of Administration. The State Board of Administration, the State Division of Retirement, and the State Department of Management Services are required to provide such support and assistance as directed by the terms of the letter of agreement and are authorized and directed to provide for health care insurance, including mental health and dental coverage for Wilton Dedge, the expense of which shall be borne by Wilton Dedge. Access to state education programs shall be provided on a scholarship basis without tuition or fees, provided that Wilton Dedge shall be required to meet and maintain the regular admission requirements of, and be registered at, such state educational program. After March 6, 2005, the Chief Financial Officer is no longer authorized to draw a warrant under this section.

Section 4. The State Board of Administration shall disburse funds under the letter of agreement upon delivery by Wilton Dedge to the Chief Financial Officer, the State Board of Administration, the President of the Senate, and the Speaker of the House of Representatives of all of the following:

(1) An executed release and waiver on behalf of Wilton Dedge and his parents, heirs, successors, and assigns forever releasing the State of Florida and any agency, instrumentality, officer, employee, or political subdivision thereof or any other entity subject to the provisions of s. 768.28, Florida Statutes, from any and all present or future claims the claimant or any of his parents, heirs, successors, or assigns may have against such

enumerated entities and arising out of the factual situation in connection with the conviction for which compensation is awarded.

(2) An order from the court having jurisdiction of the legal claim filed by Wilton Dedge and his parents dismissing the claim with prejudice, provided that it is the intent of this legislation to allow Wilton Dedge to obtain full expungement of the judicial and executive branch records of his conviction as otherwise provided by law.

Section 5. The Legislature shall not be deemed by this act to have waived any defense of sovereign immunity or to have increased the limits of liability on behalf of the state or any person or entity subject to the provisions of s. 768.28, Florida Statutes, or any other law.

Section 6. This award is intended to provide sole compensation for any and all present and future claims arising out of the factual situation in connection with Wilton Dedge's conviction and imprisonment. No further award for attorney's fees, lobbying fees, costs, or other similar expenses will be made by the state.

Section 7. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 41B Judges
SPONSOR(S): Goodlette
TIED BILLS: **IDEN./SIM. BILLS:** SB 14B

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Fiscal Council		DeBeaugrine	Kelly
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

The Supreme Court issued Order No. SC04-2154, dated November 30, 2004, certifying the need for 110 additional judges. During the 2005 Legislative Session, 35 circuit court and 20 county court judgeships were established (chapter 2005-150, Laws of Florida).

This bill revises sections 26.031 and 34.022, Florida Statutes, as amended by chapter 2005-150, Laws of Florida, creating 3 new circuit court judgeships in the Twentieth Judicial Circuit and 2 new county court judgeships in Collier County effective January 2, 2006. Judges for these new positions will be appointed by the Governor.

The bill authorizes General Revenue funds for the State Court System of $643,372 to fund 11 positions for Fiscal Year 2005-2006. This includes the 5 new judges plus associated support staff. Estimated annual recurring costs are projected to be $1.2 million.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:
This bill does not appear to implicate any of the House principles.

B. EFFECT OF PROPOSED CHANGES:

Certification of Need for Additional Judges
Section 9, Article V of the State Constitution requires the Florida Supreme Court to recommend to the Legislature the need for additional judges. The Florida Supreme Court was directed in budget proviso to the 1998 General Appropriations Act to develop "a Delphi-based case load weighting system to determine the optimum caseloads for circuit and county judges and to determine the need for additional circuit and county court judges." The system was used to develop the Court's latest certification of need for new trial court judgeships.

As a result of the last caseload analysis, the Supreme Court issued Order No. SC04-2154, dated November 30, 2004, certifying the need for 67 circuit, 41 county and 2 appellate judges for a total of 110 new judges.

The Supreme Court's Certification Order recommended 3 judges for the Twentieth Circuit and 2 judges for Collier County.

2005 Legislation
Senate Bill 2048 passed during the 2005 Legislative Session (chapter 2005-150, Laws of Florida), creating 35 new circuit court and 20 new county court judgeships. The bill staggered the effective dates: 18 circuit and 10 county judge positions were effective on November 1, 2005 and 17 circuit and 10 county judge positions are effective on January 2, 2006.

Circuit court positions were established as follows:
- Four judges each for the Tenth and Thirteenth Circuits;
- Three judges each for the Fifth, Sixth, Eleventh, Seventeenth and Nineteenth Circuits;
- Two judges each for the Seventh and Ninth Circuits;
- One judge each for the First, Second, Third, Fourth, Eighth, Fourteenth, Fifteenth and Eighteenth Circuits.

County court positions were established as follows:
- Two judges each for Broward and Hillsborough County.
- One judge each for Bay, Brevard, Duval, Hernando, Lake, Lee, Manatee, Martin, Miami-Dade, Orange, Palm Beach, Pasco, Pinellas, Seminole, St. Lucie, and Volusia Counties.

No new judges were authorized for the Twentieth Circuit or any of the counties that make up the Twentieth Circuit.

Effect of This Bill
HB 41B increases the number of circuit judges for the Twentieth Circuit from 23 to 26 and increases the number of county court judges for Collier County from 3 to 5. The bill also authorizes 11 positions and provides $643,372 from the General Revenue Fund to the State Courts System to cover the cost of the judges and associated supported staff. Support staff consists of a law clerk and 3 judicial assistants for the circuit and 2 judicial assistants for the county. Judges will be appointed by the Governor and take office on January 2, 2006.

C. SECTION DIRECTORY:

Section 1. Amends section 26.031, Florida Statutes, as amended by section 2 of chapter 2005-150, Laws of Florida, providing for 3 new circuit judges for the Twentieth Circuit effective January 2, 2006.
Section 2. Amends section 34.022, Florida Statutes, as amended by section 4 of chapter 2005-150, Laws of Florida, providing for 2 new county judges for Collier County effective January 2, 2006.
Section 3. Provides that the judges filling the new offices shall be appointed by the Governor.
Section 4. Provides the State Court System with an appropriation from the General Revenue Fund, 11 new positions and associated salary rate.
Section 5. Provides that the act shall take effect upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill provides for an appropriation of $643,372 from the General Revenue Fund to cover the cost of the 11 positions for approximately one-half of Fiscal Year 2005-2006. Subsequent annual recurring appropriations will be approximately $1.2 million. Salary rate of 877,168 is provided to enable the courts to pay currently authorized salary amounts for judges and to authorize salaries at 10 percent above the minimum for the respective pay range for support staff.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

The cost of county judges and judicial assistants are paid for by the state. Under section 29.008, Florida Statutes, counties are responsible for facilities, security, communications and information technology costs for county and circuit courts. This bill could result in additional costs in these areas. In addition, the bill could result in an increase in the workload of the clerk of the courts in the Twentieth Circuit and in Collier County.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to affect municipal or county government.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

N/A

A bill to be entitled

An act relating to judges; amending s. 26.031, F.S.; revising the number of circuit court judges in the 20th judicial circuit; amending s. 34.022, F.S.; revising the number of county court judges in Collier County; providing for the additional judges provided under the act to be appointed by the Governor; providing an appropriation and authorizing positions and approved salary rate; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Effective January 2, 2006, section 26.031, Florida Statutes, as amended by section 2 of chapter 2005-150, Laws of Florida, is amended to read:

26.031 Judicial circuits; number of judges.--The number of circuit judges in each circuit shall be as follows:

JUDICIAL CIRCUIT	TOTAL
(1) First	22
(2) Second	16
(3) Third	7
(4) Fourth	32
(5) Fifth	28
(6) Sixth	44
(7) Seventh	26
(8) Eighth	13
(9) Ninth	40

(10) Tenth 26
(11) Eleventh 77
(12) Twelfth 19
(13) Thirteenth 41
(14) Fourteenth 10
(15) Fifteenth 35
(16) Sixteenth 4
(17) Seventeenth 56
(18) Eighteenth 25
(19) Nineteenth 18
(20) Twentieth .....26 ~~23~~

Section 2. Effective January 2, 2006, section 34.022, Florida Statutes, as amended by section 4 of chapter 2005-150, Laws of Florida, is amended to read:

34.022 Number of county court judges for each county.--The number of county court judges in each county shall be as follows:

COUNTY		TOTAL
(1)	Alachua	5
(2)	Baker	1
(3)	Bay	4
(4)	Bradford	1
(5)	Brevard	9
(6)	Broward	28
(7)	Calhoun	1
(8)	Charlotte	2

(9) Citrus 1
(10) Clay 2
(11) Collier .....5 ~~3~~
(12) Columbia 1
(13) DeSoto 1
(14) Dixie 1
(15) Duval 16
(16) Escambia 5
(17) Flagler 1
(18) Franklin 1
(19) Gadsden 1
(20) Gilchrist 1
(21) Glades 1
(22) Gulf 1
(23) Hamilton 1
(24) Hardee 1
(25) Hendry 1
(26) Hernando 2
(27) Highlands 1
(28) Hillsborough 17
(29) Holmes 1
(30) Indian River 2
(31) Jackson 1
(32) Jefferson 1
(33) Lafayette 1
(34) Lake 3
(35) Lee 7
(36) Leon 5

(37)	Levy	1
(38)	Liberty	1
(39)	Madison	1
(40)	Manatee	4
(41)	Marion	4
(42)	Martin	3
(43)	Miami-Dade	42
(44)	Monroe	4
(45)	Nassau	1
(46)	Okaloosa	3
(47)	Okeechobee	1
(48)	Orange	16
(49)	Osceola	3
(50)	Palm Beach	18
(51)	Pasco	5
(52)	Pinellas	15
(53)	Polk	9
(54)	Putnam	2
(55)	St. Johns	2
(56)	St. Lucie	4
(57)	Santa Rosa	2
(58)	Sarasota	5
(59)	Seminole	6
(60)	Sumter	1
(61)	Suwannee	1
(62)	Taylor	1
(63)	Union	1
(64)	Volusia	10

(65) Wakulla 1

(66) Walton 1

(67) Washington 1

Section 3. The judges filling new offices created by this act shall be appointed by the Governor.

Section 4. The sums of $616,776 in recurring funds and $26,596 in nonrecurring funds are appropriated from the General Revenue Fund to the circuit and county courts for the 2005-2006 fiscal year, and 11 full-time positions and 877,168 in approved salary rate are authorized.

Section 5. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1

Bill No. **41B**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Fiscal Council

Representative(s) Goodlette offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Effective January 2, 2006, section 26.031, Florida Statutes, as amended by section 2 of chapter 2005-150, Laws of Florida, is amended to read:

26.031 Judicial circuits; number of judges.--The number of circuit judges in each circuit shall be as follows:

JUDICIAL CIRCUIT	TOTAL
(1) First	22
(2) Second	16
(3) Third	7
(4) Fourth	32
(5) Fifth	28
(6) Sixth.	44
(7) Seventh	26
(8) Eighth	13
(9) Ninth	40

(10) Tenth 26
(11) Eleventh 77
(12) Twelfth 19
(13) Thirteenth 41
(14) Fourteenth 10
(15) Fifteenth 35
(16) Sixteenth 4
(17) Seventeenth 56
(18) Eighteenth 25
(19) Nineteenth 18
(20) Twentieth ..... 25 ~~23~~

Section 2. Effective January 2, 2006, section 34.022, Florida Statutes, as amended by section 4 of chapter 2005-150, Laws of Florida, is amended to read:

34.022 Number of county court judges for each county.--The number of county court judges in each county shall be as follows:

COUNTY	TOTAL
(1) Alachua	5
(2) Baker	1
(3) Bay	4
(4) Bradford	1
(5) Brevard	9
(6) Broward	28
(7) Calhoun	1
(8) Charlotte	2
(9) Citrus	1
(10) Clay	2

(11) Collier ..... 5 ~~3~~
(12) Columbia 1
(13) DeSoto 1
(14) Dixie 1
(15) Duval 16
(16) Escambia 5
(17) Flagler 1
(18) Franklin 1
(19) Gadsden 1
(20) Gilchrist 1
(21) Glades 1
(22) Gulf 1
(23) Hamilton 1
(24) Hardee 1
(25) Hendry 1
(26) Hernando 2
(27) Highlands 1
(28) Hillsborough 17
(29) Holmes 1
(30) Indian River 2
(31) Jackson 1
(32) Jefferson 1
(33) Lafayette 1
(34) Lake 3
(35) Lee 7
(36) Leon 5
(37) Levy 1
(38) Liberty 1
(39) Madison 1
(40) Manatee 4

(41)	Marion	4
(42)	Martin	3
(43)	Miami-Dade	42
(44)	Monroe	4
(45)	Nassau	1
(46)	Okaloosa	3
(47)	Okeechobee	1
(48)	Orange	16
(49)	Osceola	3
(50)	Palm Beach	18
(51)	Pasco	5
(52)	Pinellas	15
(53)	Polk	9
(54)	Putnam	2
(55)	St. Johns	2
(56)	St. Lucie	4
(57)	Santa Rosa	2
(58)	Sarasota	5
(59)	Seminole	6
(60)	Sumter	1
(61)	Suwannee	1
(62)	Taylor	1
(63)	Union	1
(64)	Volusia	10
(65)	Wakulla	1
(66)	Walton	1
(67)	Washington	1

Section 3. <u>The judges filling new offices created by this act shall be appointed by the Governor.</u>

Section 4. The sums of $517,568 in recurring funds and $20,214 in nonrecurring funds are appropriated from the General Revenue Fund to the circuit and county courts for the 2005-2006 fiscal year, and 9 full-time equivalent positions and 705,157 in approved salary rate are authorized. The sum of $41,846 in recurring funds is appropriated from the General Revenue Fund to the Office of the State Attorney 20th Circuit for the 2005-2006 fiscal year, and 2 full-time equivalent positions and 58,791 in approved salary rate are authorized.

Section 5. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.

========== T I T L E A M E N D M E N T ==========

Remove Title and insert:

An act relating to judges; amending s. 26.031, F.S.; revising the number of circuit court judges in the 20th judicial circuit; amending s. 34.022, F.S.; revising the number of county court judges in Collier County; providing for the additional judges provided under the act to be appointed by the Governor; providing appropriations and authorizing positions and approved salary rate; providing effective dates.